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STATISTICAL POLICY FOR AN AGING AMERICA

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON
ENERGY, NUCLEAR PROLIFERATION, AND
GOVERNMENT PROCESSES

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS

AND THE

SUBCOMMITTEE ON AGING

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
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STATISTICAL POLICY FOR AN AGING AMERICA

MONDAY, JUNE 3, 1986

U.S. SENATE, SUBCOMMITTEE ON ENERGY, NUCLEAR PROLIFERATION, AND GOVERNMENT PROCESSES OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS AND THE SUBCOMMITTEE ON AGING OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,

Washington, DC.

The subcommittees met at 10:06 a.m., in room SD-342, Dirksen Senate Office Building, Hon. Thad Cochran and Hon. Charles E. Grassley (chairmen of the subcommittees) presiding.

Present: Senators Cochran, Grassley, and Glenn.

OPENING STATEMENT OF SENATOR GRASSLEY

Senator GRASSLEY. I would like to call this hearing to order. I am Senator Grassley, chairman of the Subcommittee on Aging, and I am pleased to join with my colleague, Senator Cochran, in cochairing this hearing to examine the statistical policy for an aging America.

Of course, I would like to explain, for Senator Cochran's part, that he is tied up for a short period of time. I believe he is at the White House. He is going to join us very shortly, and it is my understanding that he will be here, once he arrives, for the duration of the hearing.

Today, one in eight Americans has celebrated their 65th birthday, and the older generation is growing twice as fast as the younger generation. Many have called this unprecedented increase in the elderly population really a demographic revolution. The truth is that it is just the beginning of a revolution. This is but the opening roll of that drum. The crescendo will occur early in the next century, when the baby boom generation begins to retire.

In the next four decades, in 2025, one out of five Americans will be age 65 or older, and one out of three will be aged 55 or older. During this time the number of people needing long-term care will have more than doubled to 13 million people. To put this figure in perspective, this is the equivalent of all of the people of six New England States.

The impact of the aging of the population is being felt in the short term as well as the long term. The Medicare Trust Fund may run out of money in the middle of the next decade. Shortly after that time, by the turn of the century, the very old population, who are the highest users of the health care in this country, will have doubled to almost 5 million people.

The challenge is very clear. In less than 25 years, an aging society will be upon us, whether we have the information to plan for it or not. Today, we will hear from witnesses who will describe the importance of building an information base which enables us to make intelligent policy decisions about the future.

We will also hear about the policy impact of the budget process on statistical systems. The political reality is that we need more and better information with comparatively less financial resources. This is a very important topic, and it is very inportant for those of us who are working toward reduced spending and increased productivity and cost efficiency in Government.

I would like to commend Dr. Keane, the Director of the U.S. Bureau of the Census, and Dr. Williams, Director of the National Institute on Aging, for having the foresight to call for greater coordination among those agencies responsible for administering the major data systems collecting information on the elderly. I look forward to hearing more about their plans for setting up an interagency forum which will continue their efforts.

I would like to take this opportunity to mention that along with the published record of this hearing, and other related materials of our two subcommittees, we will jointly publish a handbook prepared by the Committee on National Statistics of the National Academy of Sciences which lists all of the major data systems which presently collect information on the elderly, along with the type of information they collect. We will also jointly publish a separate volume that will include the hearing records, additional testimony submitted for the record, a summary of the summit conference that will be discussed today, and recommendations for the questions for the 1990 census and analysis of the impact of the budget cutbacks on Federal data collection systems.

We think these publications will be tremendously valuable to Federal officials and others working in the area, and of course, it will be available sometime in early fall.

I want to now turn to my colleague, Senator Glenn from Ohio, for his opening statement, and anything else that he wants to do at this particular time.

OPENING STATEMENT OF SENATOR GLENN

Senator GLENN. Thank you very much, Mr. Chairman. I commend you for holding this hearing to promote an efficient and cost-effective system for developing statistical policy in an aging America.

I think this could well be broadened out to apply not only to an aging society, but it could be broadened out to say statistical policy for all agencies of Government. Because I think with almost any thesis that we have these days in Government, we also can find statistics to back up a preconceived view—that there are that many different statistical studies going in that many different statistical directions.

So I guess I am reminded a bit of the averages joke in times past about the fellow that drowned walking across the river whose average depth was 3 feet, and it just shows that you can prove almost anything by statistics and averages.

But there are some facts with regard to this statistical policy with regard to an aging America that are appropriate. As the chairman already mentioned, one out of eight Americans are 65 and over and all too many of us are joining those ranks on an increasing basis. I am about to join that crowd myself in a couple of months, so this gets very personal with me.

There are some facts that we do know. The population is aging, and today, 12 percent of Americans are 65 and older. In 2025, it is estimated it will be 20 percent, or one out of five. The fastest growing segment of our population is the group aged 75 and over, and during this century, we have seen a great increase in life expectancy. That we can all be grateful for. I wouldn't want the option, the alternative. Women outlive men by an average of 7 years, and thus the economic, the health, and the social problems of the elderly are primarily the problems of women. Nearly 55 percent of women 16 and older make up over 50 percent of the work force today.

We need to address the important changes that are reshaping American society and opening gaps between our current policies and our future needs. For instance, Social Security was enacted at a time when the traditional family consisted of the husband, who earned a sufficient income to provide for his wife, who was a homemaker, and their children. Because women have entered the work force in such great numbers and because of the increase in single-headed households, that traditional family of the past now represents only 10 percent of the population. Reforms are needed in Social Security which recognize the changes that have taken place in families since the 1930's.

Now is the time to do some long-range planning, to take the actions needed in order to meet the challenges presented by the aging of our society and the changing roles of women, in particular. For this reason, I held a series of hearings in Ohio during the past 18 months as ranking Democrat of the Special Committee on Aging, and these hearings were entitled, "Women in Our Aging Society." Many of the issues that were raised at these hearings and the recommendations that were made are ones that I expect we will be discussing this morning in the context of data needs.

Important questions include:

How can we promote a healthy old age and close the gap in life expectancy between men and women?

What must be done to ensure adequate retirement income for future generations of elderly persons, particularly women?

Who will be the caregivers of the future, given the increased labor force participation of women? And how can we provide the help they need in order to continue to juggle a career as well as caring for their children, their spouses, and also elderly family members?

What will be the health and economic status of particular segments of the over-65 population, particularly the old-old, who are most likely to need long-term care for chronic conditions such as hip fractures and Alzheimer's disease?

We have an idea of what needs to be done and what the Federal role should be. As I have done in the past, I certainly will continue to vote to preserve Social Security and Medicare and to oppose some of the proposals from time to time for just across-the-board spending cuts. But in order to improve these programs of vital importance to all Americans, as well as other programs such as housing and social services, we do need reliable and usable data, data of sufficient reliability on which we can base programs, programs that do cost a lot of money. Particularly in this time of huge budget deficits, it is unlikely that Congress will enact new programs without good information about the need for them and about their cost-effectiveness in the long term.

It is imperative that we have the necessary information on which to base our policy decisions regarding today's elderly and future generations of elderly in the very important areas of socioeconomic and health status, employment and retirement, living arrangements, and family and community supports. It makes sense that the Federal agencies and others who are collecting data about the elderly should work together and build on each other's work as much as we possibly can. And I would be interested to learn more about what is being done, or could be done, on an international level. I think that is an area that we ignore sometimes.

Dr. Frank Williams, Director of the National Institute on Aging, who will testify today, joined me at a very interesting hearing, "The Graying of Nations II," last summer in New York City at the time of the 13th International Congress of Gerontology.

We had witnesses there from around the world, from the PRC, People's Republic of China, and from the Soviet Union, people who are in charge of their studies on old age, their old age studies in those nations. It was very interesting to see those people interact with people from Sweden and Japan and other nations in sharing information on what is being done with studies and data being gathered in their areas. It was an extremely interesting meeting.

These witnesses from around the world discussed the importance of collaboration and sharing breakthroughs in the areas of basic aging research and geriatric training and the provision of home- and community-based services.

Mr. Chairman, again, I thank you for holding this important hearing, and in particular, I want to thank the witnesses who are participating today. I look forward to your recommendations. By working together, we can be prepared for the senior boom, which we know will be upon us early in the next century, and I guess the senior boom is naturally a follow-on to the baby boom, and we are going to be into it one of these days. It is going to cause us a lot of problems. We need to be better prepared for it, maybe, than we have in some of these situations in the past where we have just waited too long and then tried to react after the problem was upon us. I am glad we are getting into this in advance of that.

I have another hearing this morning I have to go to. I hope to be back a little bit later during the question period. We will go through all the statements, and, Mr. Chairman, I would hope that we may be able to submit additional questions to the members of the panel. I am sure there will be a long list of questions for them today, and I hope they can answer them for inclusion in the record to be of benefit for everyone.

Senator **GRASSLEY**. Let me follow on what Senator Glenn just said, because not only will Senator Glenn, as he just indicated, submit questions in writing, I assume that you probably know that each member may submit questions in writing, because there are conflicts in committee meetings.

So just expect that you might, each witness, get questions in writing and that we would like to have those returned. I think the normal time is 15 days, so the record will be open 15 days.

I, too, would follow on what Senator Glenn said about thanking the witnesses that are on the list already, a blue ribbon group, if we have ever had one, and in an area like this where we are looking into the future, we need that sort of expertise, and we have it here.

Before I call Dr. Brody, who is at the table now, he has 15 minutes assigned to him, and the other witnesses have been asked to confine their summary to 5 minutes. Please understand that even without your asking, unless you say something to the contrary, your printed statement will be submitted and printed in the record as submitted, and we accept that. You don't have to waste a lot of your 5 minutes thanking us for having this hearing, because we owe you the thanks for taking time from your busy schedule, and you don't have to waste a lot of your 5 minutes for permission to put your entire statement in the record.

With that in mind, I would like to introduce for the committee and for all the people in the audience Dr. Jacob A. Brody. He is dean of the School of Public Health at the University of Illinois. Dr. Brody is a well-known expert in epidemiology, demography, and biometry, and we are pleased to have him here today to provide background information on statistical policy in an aging America.

So thank you, Dr. Brody, for coming all the way from Chicago to give us your insights. I understand that you have, as I can see in front of you, your slide projector ready to go to give us this presentation. I would suggest that you begin just as you had planned.

TESTIMONY OF JACOB A. BRODY, M.D., DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF ILLINOIS AT CHICAGO

Dr. **Brody**. Thank you very much. I am grateful for the opportunity to appear before you and discuss population changes and the critical need to monitor health and disease during this period of extraordinary growth in the older segments of our population.

It is difficult to comprehend that in 1900, only 25 percent of people lived beyond age 65, while by 1985, approximately 70 percent survived age 65 and more than 30 percent lived to be 80 or more. Almost 20 percent of our population dies after age 85, and if present trends continue, within the next 10 to 20 years, almost half of deaths will occur after age 80. Most medical attention and costs are expended during the last years of life. Thus, at the turn of the century, our resources were devoted to illnesses in children and young adults.

Now, almost all our care goes to people well over age 65. This first figure[1] reveals the rapid decline in mortality rates from 1900 until 1980. Half the gain, as you can see on the bottom line, occurred this century, by 1920, suggesting that better living conditions, sanitation, and nutrition played the major role in reducing mortality and extending life this century.

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[1] See p. 65.

The downward drift persisted until about 1945 and then suddenly leveled off for almost a quarter of a century. During those years, it was assumed that we had reached the maximum life expectancy, and the formulation of many of our Social Security and Medicare policies developed under this faulty assumption.

If we had had better data collection systems and analyzing capacity during that period, we would have been more cautious. We would have seen that life expectancy was increasing steadily and that, simultaneously, heart attack deaths were increasing sharply, and these two factors nullified each other, producing what appeared to be a horizontal line for the years 1945 to 1968. In 1968, the sharp decline in mortality resumed and still persists as the grip of heart disease weakens.

Please recall at the beginning of my discussion I mentioned that in 1900, only 25 percent of the population survived to be 65, while now, about 70 percent survive to be 65. Thus, this rapid decline since 1968 is essentially the result of prolonged life expectancy among the elderly.

We would like, of course, to claim full credit for the declines in heart attack deaths as the result of our improved lifestyles and medicines. These changes, however, had not really occurred by 1968, and the specific items, such as eating less fat and smoking less, are essentially American phenomena and not observed in countries such as Sweden and Japan, where people live longer than we do. Several issues loom somewhere beyond our current understanding. We are clearly living longer. We do not know when the increasing longevity of the elderly will taper off, and we don't really know what is causing the present life extension.

The central issue raised by increasing longevity is the issue of net gain in active functional years versus total years of disability and dysfunction. Present data are weak but suggest that for each good active functional year gained, we add about 3.5 compromised years. This debit is piling up. We should be devoting our best minds to improving information about how well or badly we are doing during our increased years.

At present, our statistical measurements are sparse and crude, leaving us with gaps and guesses. This prevents appropriate planning and intelligent preparation of the population and their own or, should I say, our own aging. And as usual, the best is yet to be.

In this slide,[1] I show the classic population pyramid for 1980 with the youngest segment of the population at the bottom and women on the right, and the baby boomers being about 20 to 40 years of age. By the year 2000,[2] we note that the open portion, which is the oldest age group, is filling up. Instead of 26 million over age 65 in 1985, there will be about 34 million, and the baby boom is aged 40 to 60. By 2030, we really don't have a pyramid at all.[3]

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[1] See p. 66.
[2] See p. 67.
[3] See p. 68.

There are more than 60 million people 65 and over, and they are 20 percent of the population. As the population ages, diseases and conditions associated with older people will predominate. Note that hip fracture occurs at an average age of 79 and Alzheimer's disease at about age 80. The higher the percentage and the larger the size of our population above these ages, the greater the risk and impact of these conditions.

To make my point more emphatic, the next slide[1] projects the number of Americans who will have hip fracture. This is through 2050. There are about 200,000 hip fractures per year in the United States currently, and by the year 2000, this will have risen to almost 350,000. Since repairing hip fracture is a surgical procedure, we must be careful in our planning to be sure that we have enough surgeons and surgical suites to operate on this increased number of people. By the year 2050, there will be more than 650,000 hip fractures occurring in the United States.

This next slide[2] illustrates Alzheimer's disease, a much more common disorder of the elderly. There are now in excess of 2 million patients with Alzheimer's disease. By the turn of the century, there will be almost 4 million people with Alzheimer's disease, and by 2050, this number will have risen to almost 9 million.

My final graph[3] presents projections for nursing home residents. There are currently 1.3 million people over age 65 in nursing homes. Their median age is about 82 years. By the year 2000, there will be approximately 2.5 people in nursing homes, and by 2050, the number will have risen to 5.5 million.

I ended with the slide of nursing home data because nursing home use is a portion of long-term care for which the highest degree of knowledge and solid information is necessary. Our goal must be the prevention of the need for long-term care and postponement of its use. We must have very accurate methods for measuring illness and disability as they contribute to the need for long-term care.

These data are extremely difficult to collect, analyze and interpret. We must use carefully designed surveys and longitudinal studies to document the natural history and progression of humans as they age in this unprecedented period in which the aged are not only becoming more numerous, but are living longer all at once. Without documentation of the population increase and of the specific causes for loss of function and need for long-term care, we remain on the receiving end of paying for an increased need which can be handled less and less well in future years by current means.

We now depend very heavily for long-term care on family and other social supports. In the years to come, families will be smaller, and women will be working. This puts a predictable strain on the system which we must quantify in order to determine needs.

My projections are not comforting. Knowledge, however, gained by carefully accumulating accurate data from well-designed statistical investigations will alleviate much of our discomfort and allow us to plan and manipulate our futures. The insurance companies are exploring the feasibility of private sector coverage for long-term care. The insurers' projections speak with optimism only about insuring the healthy and affluent elderly. They caution that to make a profit, it may be necessary to start mass long-term care insurance coverage at very early at and probably unacceptable ages.

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[1] See p. 69.
[2] See p. 70.
[3] See p. 71.

The source of confidence-building and courage for ourself, our insurers, and our population lies in careful documentation of health, disease, functional status, and financial realities. This can only be learned through continued expanded and improved data collection, analysis and interpretation. Given the options, I would rather have a printout than a black box.

Thank you very much.

Senator GRASSLEY. Thank you very much. You didn't take up the full 15 minutes, but you were able to put forth some very sobering testimony but also very enlightening testimony. I want to say that I guess that what is sobering about it is in this day and age, to know that we have to be alerted to this happening, it is fine that we would be pricked into thinking more about that. This is the purpose of the hearing. But also, we thank you for telling us how we can take advantage of a better statistical base to be on top of this to a better extent.

Thank you very much.

Dr. BRODY. Thank you, sir.

Senator GRASSLEY. Our second panel includes Dr. T. Franklin Williams, who is the Director of the National Institute on Aging. We also have Dr. Jack Keane, the Director of the U.S. Bureau of the Census. I would like to have both of you come to the table at the same time, Dr. Keane and Dr. Williams. It is my understanding, for the benefit of the audience, that they will discuss the results of a forum they organized on May 2 of this year to explore how the statistical system can provide the data needed to answer policy questions for an aging society in a cost-effective way.

I need to compliment each of you in your positions of leadership for taking this step of interagency cooperation. So I would ask you, Dr. Williams, to start, please, and then before I ask any questions, I would ask Dr. Keane to follow on with his testimony.

TESTIMONY OF T. FRANKLIN WILLIAMS, M.D., DIRECTOR, NATIONAL INSTITUTE ON AGING, AND JOHN G. KEANE, DIRECTOR, BUREAU OF THE CENSUS

Dr. WILLIAMS. Thank you, Senator Grassley.

I welcome this opportunity to report on a May 2 meeting that was held to advance the coordination among Federal agencies of a statistical policy for the aging population. The rapid increases in the number and proportion of older people in our Nation, particularly those who are in their eighties and nineties confront us with challenges of historic proportions. The National Institute on Aging and other agencies concerned with older people depend heavily on the Federal statistical system in order to understand and interpret changes that are underway and to plan effectively for the future.

To identify issues and opportunities relating to aging statistics, and to increase the formal and informal collaboration among Federal agencies, Dr. Keane and I convened a meeting on the National Institutes of Health campus on May 2. Eleven directors of Federal agencies were in attendance, as well as 55 additional participants and observers representing 42 Federal and non-Federal organizations, including 12 institutes of the NIH, 10 other agencies within the Department of Health and Human Services, and 9 from other Federal agencies. A full list of participants and observers has been submitted for the record.[1]

Every Federal agency was invited to submit a statement of the vital issues in aging-related statistics, and these statements, together with a summary outline of the issues therein, are also submitted.[2] Let me just summarize here some of the substantive and procedural issues that were raised in the statements and also in our discussions at the meeting, as well as some of the overall recommendations.

These agencies called for more and better information on the elderly population in a number of epidemiological, demographic, and economic areas, including the utilization of services and projection of needs for services. Despite the fact that each agency focused on its own mission, there were, indeed, many common threads and considerable agreement. For example, a large percentage of the statements called for improved data on the institutionalized population, which Dr. Brody has just described as growing at a considerable rate. Many statements also called for better measurement of morbidity, disability, and risk factors; for more accurate data on causes of death; for improved information on the health costs of diseases and of the services needed; and, for more data on the employment and financial status of older people.

Almost all the agencies noted the importance of bridging gaps, particularly the gap between health and socioeconomic data, of providing comprehensive and longitudinal data in certain areas, and of disaggregating published statistics beyond the age of 65. This is a very important to do since, up to now, so many of our statistics have been lumped together for everybody beyond age 65. A number of statements noted the importance of oversampling important groups such as the oldest old. We also need to improve the quality of the data collected, especially on cognitively impaired persons.

In terms of the recommendations from this meeting, the participants agreed on the need to improve coordination and collaboration among agencies. Other potentially interested agencies should be brought into any agency's planning of surveys at early stages. The opportunity for piggy-backing of questions to reduce costs should be accomplished wherever possible, and systems that combine health and socioeconomic data should be developed collaboratively.

The two agencies that are most central to the collection of these data, the National Center for Health Statistics and the Bureau of the Census, need to continue to develop and share technical expertise in the problems of collecting adequate and high-quality data on the elderly. The National Institute on Aging can help in supporting research in these efforts. Finally, it was agreed that there is a need to establish a focus and mechanism for further collaboration on aging statistics among all these agencies. Dr. Keane will speak to that need.

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[1] See p. 73.
[2] See p. 85.

Senator **Grassley**. Dr. Keane.

Mr. **Keane**. I will take the chairman's admonition to heart, and I thank him, but I truly commend you.

Senator **Grassley**. OK.

Mr. **Keane**. And also Senator Cochran for calling this kind of a hearing early. I am honored to join my distinguished colleagues from the National Institute on Aging, the Social Security Administration, the National Center for Health Statistics, and others testifying.

This conference that Dr. Williams spoke of on May 2 was a first-of-its-kind effort to gather directors of Federal agencies concerned with the collection of data on the older population. The single issue identified as most important in development of aging-related statistics was to establish cooperative actions among our Federal agencies. Clearly, cooperation is seen as a way to extend our agency's capabilities to meet our goals in a cost-efficient way.

Through cooperation, we can improve our ability to link data collection and research to funding and policy development. We can provide better information for establishing priorities in data collection and research that meet the tests of scientific value, social relevance, and affordability.

By working together, we will be better able to isolate funding and policy-related areas, needed data, and to fill those data gaps. We expect that one important outcome of our cooperative action is that we will be able, for example, to begin to integrate health and socioeconomic data. We can extend the use of limited resources, avoid waste, and work toward a uniform, complimentary approach across Federal agencies where appropriate.

We can also improve access and dissemination of data for planning, program management, and development of policy options. By recognizing our mutual interests, we can encourage collaborative research. To date, there has been no formal effort to promote cooperation or to identify vital data gaps that need to be filled to answer policy issues related to an aging society.

Within the Federal Government, there are two primary agencies concerned with the production and analysis of aging-related statistics: The Bureau of the Census produces demographic, social, economic, and housing data. The National Center for Health Statistics produces health data. In addition, the National Institute of Aging coordinates and promotes research into various factors related to aging.

Because of the research and funds, the National Institute on Aging is at the cutting edge of knowledge about data needs that can provide unique insight to data collection agencies. Many other agencies produce data on specific subjects that are relevant to the study of aging. The participants of the summit meeting unanimously agreed to promote cooperation and coordination among Federal agencies through the establishment of an interagency forum on aging-related statistics. Each agency director will appoint a senior staff person able to make broad policy decisions. Technical staff will work with the forum, and working committees will be organized to address specific issues.

The forum will be jointly chaired by the Census Bureau and the National Center for Health Statistics. The agency directors will stay closely involved with the forum, acting as an oversight committee that will meet twice a year. The oversight committee will be chaired jointly by the Directors of NIA, the Census Bureau, and the National Center for Health Statistics.

The forum will provide us with a formal structure for the exchange of information about needs at the time new data are being developed or changes are being made in existing data systems. Through this forum, our various agencies may also be able to:

One, identify data gaps, potential research titles, and inconsistencies among agencies in the collection and presentation of data related to the older population; two, create opportunities for joint research and publications among the agencies; three, improve access to data on older persons by serving as a coordinating point for data requests from Congress, governmental agencies and other data users; holding meetings with data users to gain better understanding of their data needs and producing reference reports; four, develop joint funding for projects involving aging-related statistics of mutual need among agencies; five, identify statistical and methodological problems in the collection of data on the older population and investigate questions of data quality; and six, work with other countries—I think Senator Glenn brought out this point—work with other countries to promote consistency in definitions and presentation of data on the older population.

That concludes may observations about the summit conference.

Senator **Grassley**. I have just a few questions, a couple of things that I want to bring out that kind of involve the administrative relationship. I know you have already addressed that to a considerable extent, but there are a couple of things that may be more addressed. To both of you, I would make the proposition that it is my understanding that part of the idea behind the interagency forum is to set up two Federal centers on aging-related statistics: One would address social, economic, and housing issues, and it would be based at the U.S. Bureau of the Census, and the other would address health issues, and it would be based at the National Center on Health Statistics.

Now, what would be the relationship between these centers and the forum?

Mr. **Keane**. The forum would be an interagency group, including both the representatives of the earmarked agencies, as well as the oversight committee. That would be what a forum does, in the sense that it would be the clearing house of ideas; it would be a place for discussion; it would be the opportunity to address where identified data gaps are and what to do about them in the way of recommendations. It would be, in the broad sense of the term, both the oversight function as well as from an agenda standpoint, looking at issue by issue as they emerge through the experiences of the two centers which you have identified.

At this point, since this is the aim, and it is not yet the reality, we don't have experience to go on. So, conceptually, that, at this time, is what we propose.

Senator **Grassley**. Dr. Williams.

Dr. **Williams**. I see it essentially the same way, Senator Grassley. We conceive of the forum as the meeting ground of the key people from a wide range of Federal agencies that have a real stake in both generating and using aging-related statistics. This is the direction in which we will move, continuing the process started in our first meeting—to understand each other's needs, to share resources, and to develop very specific ways to collaborate in the collection of data and analysis of data.

I see the two centers, the Bureau of the Census and the National Center on Statistics, as being the primary settings where most, but by no means all, of the relevant data will be generated, and where the great bulk of the storage and analysis capabilities will exist for sharing.

They will be the key support and service agencies, and the forum will be the overall coordinating body.

Senator **Grassley**. Now, to either one or both of you, I would like to know if you expect that the interagency forum will address the question of data overlap.

Mr. **Keane**. Most assuredly.

Dr. **Williams**. It certainly will.

Mr. **Keane**. It is one of the primary reasons for the forum.

Senator **Grassley**. Again, to either one of you or both of you, how will conflicts between agencies be resolved, if they come up?

Dr. **Williams**. We see what Dr. Keane referred to as the oversight committee as being the ultimate arbiter of conflicts. We see this as a continuation of what we began in this first meeting of representation of the directors of these participating agencies. That is, the two of us, and the Director of the National Center for Health Statistics, who you will hear from shortly, will serve as the ultimate decision body to address issues about conflict or disagreement.

Now, we can't guarantee that we will always resolve everything, but given the common interests, I don't anticipate that we are going to have any unresolved conflicts.

Senator **Grassley**. Yes?

Mr. **Keane**. Two additional comments. One is that because we have started early in the process, and involved everyone, that should lessen the opportunity and, therefore, the likelihood for conflicts to arise. Should they arise, and some surely will, as you will recall from my testimony, likely, the committee is cochaired by Dr. Williams and the head of the National Center for Health Statistics and myself, and the three of us, meaning our agencies, have established working relationships of some long standing.

Therefore, that should also help in the resolution of any emerging conflicts.

Senator **Grassley**. Can you accomplish your goals administratively, or will there be some legislative needs, and if there are any legislative needs, to what extent could we be helpful in accomplishing that?

Mr. **Keane**. Speaking for the Census Bureau, our belief at this time is that there are no legislative needs. We have the authorizations and, under title XIII, all the justification for doing what we need to do and perceive doing.

Dr. **Williams**. I agree. At the present, we see no need for any further authorization. We have adequate authorization, and as this hearing will continue to show, all of our agencies are already sharing in a number of ways—which we hope to expand.

But under current authorization, that will be quite possible.

Senator **Grassley**. You don't anticipate any problems with any Cabinet Councils or OMB on the goals you seek?

Dr. **Williams**. I don't think so.

Mr. **Keane**. I don't anticipate any. So far, the Office of Management and Budget has not taken an active role in the issue.

Dr. **Williams**. The Department of Health and Human Services has been supportive of what we are doing.

Senator **Grassley**. I have no further questions. So I would ask you to be cognizant of the requests that you might have for questions to be submitted to be answered in writing.

We were going to invite another Dr. Keane to the table, but that is not possible, so we have Dr. Feinleib and Ross. I would ask that you come and join the present members who have just spoken.

This third panel includes distinguished representatives from four of the five major research and data collecton agencies. I would like to take this opportunity to say that I am disappointed that the Health Care Financing Administration [HCFA] was not here today. Although we requested that they testify, they responded that they were also called to testify at another hearing today and that they currently do not have the staff to prepare testimony for the two hearings. They have submitted written testimony for the record, and we will be and we are going to send them a list of questions to answer based on that testimony. I assume that HCFA is testifying before another committee that I attended earlier this morning, the Subcommittee on Health and Finance, where we are looking into the extension of the prospective payment system into post-hospital needs.

Our third panel today includes Dr. Williams, Dr. Keane, already introduced, Dr. Manning Feinleib, Director of the National Center for Health Statistics, and Dr. Jane Ross, Director of the Office of Research Statistics and International Policy of the Social Security Administration. For the benefit of the audience, I expect that they will give us an overview of their Agency's activity in data collection and research on the elderly, and then they will discuss coordination from their Agency's perspectives. So would you please begin, Dr. Williams?

TESTIMONY OF T. FRANKLIN WILLIAMS, M.D., DIRECTOR, NATIONAL INSTITUTE OF AGING; JOHN G. KEANE, DIRECTOR, BUREAU OF THE CENSUS; MANNING FEINLEIB, M.D., DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS; [1] AND JANE ROSS, DIRECTOR, OFFICE OF RESEARCH, STATISTICS, AND INTERNATIONAL POLICY, SOCIAL SECURITY ADMINISTRATION [2]

Dr. **Williams**. Thank you, Senator Grassley.

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[1] See p. 33 for Dr. Feinleib's prepared statement.

[2] See p. 38 for Ms. Ross' prepared statement.

The National Institute on Aging was established by congressional mandate in 1974 for:

> The conduct and support of biomedical, social and behavioral research and training related to the aging process and to the diseases and other special problems and needs of the elderly.

Within this mandate, two of the Institute's units have primary concern with Federal statistics on older people: our extramural Behavioral Sciences Program and our Intramural Epidemiology, Demography, and Biometry Program. Our programs support research and training as well as the development of data bases and research methodologies across a wide range of disciplines.

Important research priorities for the Institute include understanding aging, of which the oldest old, those 85 and older is a major category; Alzheimer's disease; maintenance of health and effective functioning; and hip fractures and other common disabilities of older people. We also place a high priority on basic research on the aging process and on training for research and academic leadership.

Through interagency agreements with the Bureau of the Census and the National Center for Health Statistics [NCHS], our Institute has supported the develpment and analysis of data bases. Also, the Institute supports a data archival center at the University of Michigan for the use of these and other data bases by qualified investigators.

Major intramural studies under way including now a follow-up study of the older people who were part of NCHS' National Health and Nutrition Examination Survey conducted in the early 1970's, and longitudinal epidemiological studies of older people in four communities. Research methods for collection and analysis of data on older people are developed by both our intramural and extramural scientists, many of whom make intensive use of other Federal statistics.

NIA has identified a number of gaps in the Federal data system on the aging population and a number of opportunities for cost effective collaboration with other agencies. Our statement of vital issues prepared for the May 2 meeting identifies a number of these gaps. I will give only a few examples here.

First, the oldest old population is one of the fastest growing age groups in our country and has the highest burden of morbidity and disability of any age group. A very large minority are in long-term care institutions. Many nationally representative surveys, such as the National Health Interview Survey of the National Center for Health Statistics and the survey on Income and Program Participation of the Bureau of the Census, often end up with inadequate numbers of very old people for many needed analyses. The quality of the data, moreover, may be poorer than that of other age groups because of problems of collecting adequate data on very old people.

Second, there is a need for more comprehensive and longitudinal data on older people. Many suffer from multiple illnesses, and we need to know more about the interactions between the different illnesses and a number of social and economic factors. Rates of institutionalization are dependent upon multiple risk factors, and we need more information on all of these.

Many of these factors, in turn, are related to housing costs, retirement trends, trends in living arrangement, age at widowhood and the availability of long-term care insurance.

Data relevant to many of these aspects are obtained by various Federal agencies but have not often been interrelated, and more seriously, have not been reported in sufficiently small age intervals, that is, such as 5-year age intervals.

At a national level, we know comparatively little about the transition of individuals into and out of dependency and the pathways of individuals through the long-term care system. Some of our more recent data indicate, for example, that there is a significant move back out of dependency and out of long-term care institutions which has received relatively little attention up to now. Both longitudinal and comprehensive data are needed in order to understand these transitions more fully, which should also help in developing more effective methods to reduce dependency and the use of long-term care services.

Finally, a significant amount of the data that is collected is never adequately analyzed, in part because there are too few epidemiologists, demographers and statisticians who have the substantive and methodological knowledge needed in order to analyze data on older people. We need both to develop new ways to increase the number of trained scientists in this area and to increase our efforts to make data available in a timely fashion to Federal agencies and to extramural scientists.

There are a number of highly cost-effective ways to improve on what is now done, such as reporting by 5-year intervals throughout the age span; piggy-backing or sharing of surveys; linking survey data with administrative records under strict safeguarding of confidentiality, and resurveying respondents from previous surveys.

Our Institute is eager to work with the Bureau of the Census, the National Center for Health Statistics, the Social Security Administration and other agencies to accomplish these objectives.

Thank you.

Senator **Grassley**. Thank you.

Dr. Keane?

Mr. **Keane**. Chairman Grassley, the Census Bureau, as factfinder for the Nation, is responsible for the collection, compilation and dissemination of basic information on the size and characteristics of the nation's population. Through the Decennial Censuses and numerous surveys, we are able to profile the population and its demographic, social, economic and housing status.

We continually stride to improve our data collection and dissemination efforts to make our data as accurate and useful as possible. As the older population has increased and will continue to do so in the future, we have become ever more involved in effects to supply policymakers, researchers and other users with detailed information on this important segment of the population.

Some of what we are doing or hope to do is described as follows. Research on the older population can be complicated by problems that do not occur in research on other segments of the population. Here are some of the difficulties and challenges:

One, the planning and coordinating of data collection efforts for the older population will be greatly enhanced by the establishment of the interagency forum on aging-related statistics. For the first time, those agencies most intimately involved in the development of data on the older population will have a mechanism for communicating among themselves and with other users on data needs. Sharing plans for data development at the conceptual stage is vital for an efficient, useful statistical system.

Two, the issue of data quality can be particularly difficult to solve because some older respondents, particularly those in institutions, may be cognitively impaired. Further, we are examining the way we ask questions about age to ensure that the design of the questionnaire is not misleading. We are also looking at ways to use administrative records to check on the accuracy of the data we collect.

Three, as the attention of the Nation has focused on this growing segment of the population, users have asked for more detailed information on the older population, as well as for data on a particular segment, the oldest old. Two groups of efforts are being made or considered to meet these demands.

First, we plan to publish data in greater detail than in the past in the 1990 census and in surveys, including showing information for age groups within the 65 and over population and for other characteristics, such as gender, race, ethnicity, family type, and so forth.

Where surveys are the source of data, techniques such as averaging data over samples for several years or providing estimates in ranges for given levels of confidence are being used on an experimental basis to minimize the impact of too small sample sizes. With ranges, users can obtain estimates for subgroups of the older population never before available, even though the precision of the data will not equal that obtained if the sample sizes were larger.

Increasing the sample sizes would produce more precise data, but that is also expensive, especially for the oldest old, since the population 80 years and over constituted just 2.5 percent of the population in 1985. They are a small but important subgroup from a policy perspective, because it is projected that the Federal Government will spend $80 billion per year on the population 80 years and over in less than 15 years. That makes it imperative to get the most out of the data already collected.

The second kind of effort to get more detailed information concerns new data collection efforts. These range from adding supplementary questions for older respondents to ongoing surveys to linking data files with administrative record systems. Linking of data sets could be used, for example, to add detailed information on health or disability to data collected on socioeconomic status. While the linkage of records is efficient and potentially valuable, confidentiality of the data must be ensured absolutely, and privacy issues are paramount.

Four, an important part of our job is to get data to users in an understandable and useful format. We are investigating ways to make the data more accessible and to disseminate data more widely.

And five, finally, we want to facilitate the analysis of the data we produce. To that end, longitudinal data files, files that contain information on the same person over a period of time, are being created and techniques developed for using such files. These kinds of files are needed to study the impact of events on persons; for example, the impact of retirement or the death of a spouse.

Also, efforts are being made to facilitate comparisons of the status of the other population in other countries with our older population. This requires the development and use of standard definitions and tabulations. As you can see, there is much to be done, but we welcome any suggestions this committee or other users might have in that regard.

Senator COCHRAN. Thank you very much, Dr. Keane.

We now have Dr. Manning Feinleib who is the Director of the National Center for Health Statistics. Welcome to the committee.

Dr. FEINLEIB. Thank you very much, Senator Cochran. I will take Senator Grassley's admonition to proceed with the testimony, although it is difficult to not thank you directly for inviting us to these hearings and participating in these hearings.

The National Center undertakes more than a dozen different data systems to document the health of the people in this country. I will use this time to briefly summarize some of the major efforts of NCHS to produce health data on the aging population. For each activity, I will highlight some opportunities we have to increase our knowledge of the health of older persons.

One effort is producing longitudinal data, which are important to identify changes in health over time. From such data, we can follow a person from the onset of a chronic condition to disability and eventually to death; relating the impact of a variety of events such as retirement or death of a spouse to the health outcomes of the individual. NCHS has two current examples: The National Health and Nutrition Examination Followup Survey, referred to as the NHANES I Followup Survey, and the 1986 longitudinal study on aging.

The NHANES I Followup Survey has recontacted individuals who were given physical examinations more than a decade ago. The longitudinal study on aging is reinterviewing older persons who were first interviewed as part of the National Health Interview Survey 2 years ago. These surveys are giving us additional insight into risk factors which are related to the aging process and which may contribute independently on how changes in function influence longevity and admission to nursing homes.

Both surveys were the result of collaboration with NIA, and we are jointly exploring additional opportunities for longitudinal data collection. One such opportunity is to recontact families of residents surveyed in our 1985 National Nursing Home Survey to learn about discharges and readmissions. Another opportunity is to repeat the longitudinal study on aging periodically.

A second activity important to the data on aging is record linkage. The linkage of survey data with administrative records can expand our longitudinal data and is highly cost effective. Over the last several years, the National Center has developed the National Death Index. This provides a mechanism to link records from various studies to death records, which are kept by the States, and is used with all of our surveys of older persons.

We also have been discussing with the Health Care and Financing Administration the potential for linking Medicare administrative records to the samples of the two longitudinal surveys I just mentioned. A key initiative for statistical policy is to facilitate record linkage while protecting privacy and confidentiality. From our initial discussions, and as you have just heard, this is an important area of focus for the forum described earlier by Dr. Keane and Dr. Williams.

A third NCHS activity is assessing the feasibility of including older persons in the 1988 National Health and Nutrition Examination Survey. This survey is unique, because it collects data from a physical examination and from laboratory tests on each participant. Until now, this survey has excluded persons over the age of 74, mainly because of problems in examining older persons at our mobile examination centers. We are now reassessing the possibility of including people of older ages in several different ways, including conducting a limited physical examination of older persons in their homes or in minivan which can be parked nearby, rather than bringing the elderly people to our examination centers.

A fourth activity is conducting methodological research on measuring the health of older people. Some of our current activities include: The planning of two international conferences, one on the topic of measuring the health of the aging and the other one on issues of recording the underlying cause of death; focusing on how to measure the quality of life of older people, an issue of growing concern as longevity has increased; and planning a workshop on measuring the cognitive deficits in older persons, which is important to determining the prevalence of Alzheimer's disease and the ability of older persons to live independently.

Finally, the fifth activity which I would like to summarize is analysis and dissemination of our data. Our experts have prepared special analyses or mortality trends, nursing home care, the need for home care and such issues as urinary incontinence. We have collaborated with the National Institute on Aging to produce a new periodic statistical report on aging, and we have given special attention to the timely release of public use data tapes in order to allow wider access to our data by extramural researchers.

In summary, I believe we can greatly improve the relevancy and availability of health data on the aging, and increase collaboration among the agencies represented here this morning as well as many others. I am looking forward to working through the forum to enhance the relevancy of NCHS data for research and policy analysis.

Thank you.

Senator COCHRAN. Thank you very much for your excellent statement. We have as our fourth member of the panel Jane Ross, who will provide some testimony with respect to the viewpoint of an agency providing benefits to the elderly population.

Ms. ROSS. Mr. Chairman, it is a pleasure to be here today to discuss statistical policy for an aging America. The Social Security Administration welcomed the convening of the May 2 summit meeting of Federal agency heads to discuss information needs related to the aged. With so many agencies involved in collecting data relating to the aged and in operating programs to assist them, and with the need we all have to use scarce resources effectively, it is essential that we have a mechanism to assure that data gaps are filled and that we avoid duplication of effort.

We believe that the summit meeting and a continued interagency forum are positive steps toward our goals of cooperation and coordination. We share the enthusiasm being expressed by others here today about the potential for more collaborative efforts, especially the coordination of survey activities.

We also support the call for maximum use of linkages between data files, always with the strictest regard for confidentiality concerns. Further, we welcome the inclusion of operating agencies such as SSA in these interagency discussions to determine priorities among data needs.

The proposed mix of data collectors, researchers and other uses of information helps to ensure the relevance of all of our information-gathering activities. We at SSA are confident that further joint efforts will strengthen and improve the focus of our own statistical and research activities, as well as those of other participating agencies.

I would like to turn now to a brief discussion of some ongoing activities in the Social Security Administration that pertain to the aging of our society. Specifically, I would like to discuss work we have in progress to assess the economic status of the aged and to analyze the work capacity of older persons and the demand for the services of such workers.

With regard to the economic status of the aged, SSA conducts its own occasional surveys and uses the recurring surveys of the Census Bureau to assess the economic well-being of the aged and the trends over time in their economic status. For example, we recently conducted a New Beneficiary Survey, which enables us to examine in detail the economic status of current retirees and to compare their economic status to that of a cohort of new retirees surveyed a decade ago.

SSA researchers also are using the Census Bureau's Current Population Surveys and Survey of Income and Program Participation to assess the income of wealth of 5-year age groups within the aged population and to track the incomes of aged cohorts over time.

We also understand that others are contemplating a reinterview of those previously involved in our Longitudinal Retirement History Survey, which tracked, for 10 years, a group of persons approaching retirement beginning in 1969. A reinterview of that sample would provide valuable insight into what happens to the income of older persons as they age and into the economic status of the very old, those entering their eighties.

On topic of work capacity and demand for older workers, there is much interest in how increases in life expectancy will affect workers' ability and their willingness to work. For example, we are analyzing data from the National Health Interview Survey sponsored by the National Center for Health Statistics to determine trends in the health status and work capacity of older workers and to suggest whether projected increases in longevity will be accompanied by an extension of active worklives.

Another project is using data from the New Beneficiary Survey to analyze the relationship between the decision to retire and a person's occupation and health status.

Whether older workers will be willing to work longer as they live longer is another research issue. Before projections of the future can be made, better understanding is needed of past trends. A project we plan to do in-house will examine trends in retirement since 1960, using data both on labor force participation and on the ages at which Social Security benefits are first claimed. Those are two different definitions of retirement.

Whether older workers will work longer also is a function of the demand for older workers. Many private pension plans, for example, provide no incentives for older workers to continue to work. These plans pay full benefits at age 62 or they give no credit in pension calculations for work performed after age 65.

Further, the results of a recent grant sponsored by SSA suggests that few employers offer other incentives to keep their older employees working.

SSA is funding further analysis of how pension systems and employers will respond to the changing age structure of the labor force.

Many of the topics I have outlined complement and utilize the work of the National Institute on Aging, the National Center for Health Statistics, the Census Bureau, and others. We at Social Security look forward to collaborative efforts among us as we pursue common research interests.

Thank you.

Senator COCHRAN. Thank you very much, Ms. Ross, for your assistance and your testimony this morning. In looking over the topics that have been discussed by this panel, I wonder whether or not there is any difficulty in using data compiled, for instance, by the Census Bureau, which has a very strong allegiance for confidentiality and maintaining integrity of the process so that information can be obtained with those assurances being made to the general public. How is that to be integrated into a data base for sharing among other agencies without breaching that confidentiality? Is that a problem? I know Dr. Feinleib might comment on that, and Dr. Keane, as well.

Mr. KEANE. Perhaps the observations of our users would be more pertinent than ours. As you know, we acknowledge the importance of confidentiality. There is no more important shared value that I know of in the organization than the confidentiality, the protection of a responder's privacy.

But beyond that, we have always balanced it with the need and the use and benefit of our data, and as long as there is no disclosure of an individual's identity, we will share that data within our title XIII authority.

Senator COCHRAN. Dr. Feinleib?

Dr. FEINLEIB. These are essentially two types of collaborations envisioned with regard to the sharing of information. One is at the aggregate level, where you need data on subgroups of the population. With this, the Census Bureau has been extremely forthcoming.

We are trying now to determine mechanisms for sharing data at the micro level where it is important to sometimes check the characteristics of an individual, such as economic or social characteristics, to relate it to other data for that individual. Otherwise, we wouldn't know what socio-demographic "cell" to put the individual in. This is the issue that is most important now, to be able to provide mechanisms for exchanging this information while preserving the confidentiality of the data and the privacy of the individuals.

Senator COCHRAN. I noticed in the testimony of Dr. Williams there is a reference to support for a data archival center at the University of Michigan. Tell me about that center and whether or not it is an appropriate model that could be used for maintaining a data base or an accumulation of information that can be used by all of these agencies and groups.

Dr. WILLIAMS. The archival center plays a very important role in making available to the public use data that have been released for public use by a variety of studies, including studies of the agencies represented here, as well as various other research projects that are funded by NIA and other branches of the Federal Government.

After data have been carefully checked for veracity, for correctness, and have been approved for release in aggregate form—that is, not in a form in which individuals can be identified—we or the researchers provide these to the center.

The staff of the center keeps track of the data, maintains a catalog, and issues periodic announcements of its availability to the public, and scientists who are qualified and capable of analyzing these data can then acquire these data tapes or records and conduct further research analyses on them.

So it is a very important resource. I also want to emphasize that these are data that have been released for public use. Now, I believe we might see a similar arrangement, between the two proposed centers within the Bureau of the Census on the one hand and the National Institute for Health Statistics on the other. Data records that are kept within the Federal domain would be accessible to different agencies through an archival system where they are cataloged and accessible to qualified people.

I would be interested in talking to either Dr. Keane or Dr. Feinleib about this.

Senator COCHRAN. What is your reaction to that, Dr. Keane?

Mr. KEANE. I would be in general support.

Senator COCHRAN. Dr. Feinleib?

Dr. FEINLEIB. Very much so. One of our principal activities is providing public data tapes for investigators which contain data, at the micro level, for analysis, but still preserve the confidentiality of the individual person.

Senator COCHRAN. I noticed that in one statement, I think it was Dr. Williams', there was a reference to gaps in the information relating to the elderly population. I wonder if, in the development of the 1990 census questionnaire, there is being planned a group of new questions to fill in some of those gaps that are referred to.

Are we going to find out more about the elderly population in 1990 than we did in 1980?

Dr. KEANE. The answer is yes, we will find out more about the elderly population, perhaps through either modification of questions or additional questions. That is under study now through our test censuses, and probably the most important one is the one going on now, the National Content Test.

So the final decisions are yet to be made on those. There is one other issue, though, that does not involve additional questions or modification of a question that would supply more data, and that is simply having more data breaks in the elderly population than just 65 and over. In other words, under consideration now are five breaks where possible: 65 through 69; 70 through 74; 75 through 79; 80 through 84 and 85 and over.

In the 1980 census, by contrast, there were some detailed age breaks, but not as many as planned for 1990 but it is somewhat dependent on the size of the sample base on the long form questionnaire as to what item. So it will be on an item-by-item basis as to how many age breaks.

I end where I began: Yes, there will be more data on the elderly population out of the 1990 census.

Senator COCHRAN. I noticed, too, there were some comments about the economic situation of the elderly and its relationship to policy. Is it important in this forum that is trying to look at these issues for there to be policymakers as well as statisticians and information gatherers on board? What is your opinion of that, Dr. Ross?

Ms. ROSS. Well, as a representative from an operating agency, especially, where we are involved daily in operating and legislative policy, we think is critical. We all are aware of what the broad issue areas are, but on the particulars within those issue areas that need to be researched or where there is a need for particular data, we really need the input of policymakers and policy analysts as well as researchers and the data gatherers. We think the structure that has people like us, the operating agencies, involved is critical to the success of these data collection/integration efforts.

Senator COCHRAN. Dr. Keane, what is your reaction to that?

Mr. KEANE. We heartily agree that certainly, the views and concerns of policymakers ought to be reflected in there, and so the Social Security Administration was at our May 2 meeting, represented by Martha McSteen.

We would like to keep it manageable, also. By "we" I am talking about those of us who cochaired the forum. I don't know; are you thinking of applying for membership as a Member of Congress? [Laughter.]

Senator COCHRAN. I have got enough meetings to attend now. I really didn't have that in mind. I appreciate your thinking of me. [Laughter.]

Dr. Williams?

Dr. WILLIAMS. I might just add that the Health Care Finance Administration was represented in our May 2 meeting and would be a part of our ongoing forum, as well as other agencies that have a big stake in policy. Staff of congressional committees were also present. We welcomed their participation.

Senator COCHRAN. In the testimony of Dr. Ross, there was a comment about improvements in life expectancy and whether or not that has been translated into equivalent improvements in the ability of older persons to work. As I understand it, there has not been the correlation that one might assume. I was rather surprized by that.

What are the implications of that finding, or are there any?

Ms. Ross. We are not entirely sure at the moment what we have our hands around. We have done some work which indicates that it may be the case that people are being kept from death, from diseases like heart attacks. This allows them to live longer, but doesn't necessarily allow them to have more years of healthy life; they may have more years of life with a disability. So that it may be that the type of medical improvements that have occurred in the past several years have had the effect of increasing the proportion of the population in older ages that is unable to work.

One of the things we are very interested in talking with our health colleagues about in this ongoing forum is what we can do to develop better measures of the ability to work. The kinds of questions people are usually asked on surveys about activities of daily living or about what kinds of impairments they have don't really get to the heart of whether they are able to work.

Some of the kinds of questions that are asked about whether you can do your customary activity can help us to understand a little more whether the population is more or less able to work. But we think this is an area that will benefit from our exchanges with people in the health areas.

Senator Cochran. There is also a comment about retirees having greater assets than their parents and that retirees continue to save. How will this trend affect the Social Security Assistance Program, if at all?

Ms. Ross. There are certainly more older people with assets, but the amount of assets that individuals have is, on average, a very small amount. We hope that retirees will have more assets in the future; assets are one of the components of income that we expect people to have at the time of retirement.

The Social Security Administration is providing one part of our retirement income as a nation. It provides earnings replacement. But when Social Security was conceived, and certainly now, people think of it as only one part of retirement income; income from assets is the second part. Private pensions are the third part of the income that people are expected to have.

It may be that it will be more true in the future that people will have a better balance among these three than they have had in the past.

Senator Cochran. In Dr. Feinleib's statement, there is reference to standardization. Is this something where one agency is just simply going to be looked to for developing standard definitions? How will we standardize definitions that will improve the compatibility of data and information which is collected by various agencies?

Dr. Feinleib. I think that was identified as one of the main topics for the forum, which we reported on earlier. By listening to the views of the different agencies, their concerns as to what kind of information they need and what objectives they have, and what problems they have in standardizing the data, we can work together to develop standards that will be satisfactory to each of the agencies.

Senator Cochran. Improved integration of socioeconomic data with health data has been cited as an important need. Why is this important? Have any of your surveys attempted to relate socioeconomic data to health?

Dr. FEINLEIB. Yes, there are many examples where the socioeconomic level or conditions influence the health and the availability of access to health care and use of health care.

One particular example is in the use of long-term care facilities. A person's need for, and admission to, institutionalized long-term care often depends upon the number of children the person has, and whether those children are able to assist their parents in living alone. Medical eligibility is determined by what their assets are. All these things are very important in interpreting the transition from independent living to institutional living.

Senator COCHRAN. Dr. Williams, you mentioned the relatively low cost of resurveys and piggy-back surveys. Could you give some examples?

Dr. WILLIAMS. Yes, Senator Cochran. I think that this illustrates how we can really benefit by our working together. One example is the Longitudinal Survey of the Aging, which the National Center of Health Statistics is undertaking and which our Institute is helping support in order to collect more information from the respondents who are very old. We can thus get data which we think is very important, on the very old at very modest additional costs compared to what has already been invested in this survey.

Other examples that would involve the same principle might be followups to the National Nursing Home Survey; to the Social Security Administration's Retirement History Survey; and to the Health Care Financing Administration's National Long-Term Care Survey. All these examples involve followups of an already existing survey. It is thus possible to obtain, at very modest costs, much more information on specific target groups such as the oldest old.

Senator COCHRAN. We appreciate so much your responding to the questions and preparing the statement for the hearing. I am very impressed with the amount of work that has gone into this, and I hope very much that it turns out to be a helpful exercise for all of the agencies concerned and for our subcommittees, who are constantly trying to evaluate the effectiveness of our legislative initiatives and Federal programs that do affect the elderly directly.

I think we should, at this point, too, commend Dr. Keane and Dr. Williams for the initiative shown in the development of the forum and the meeting that was held in May to try to resolve some of these issues and improve the sharing of information.

That concludes the testimony of this panel. We thank you all for being here and cooperating with our subcommittee very much.

Our last panel includes Prof. Sam Shapiro, chairman of the panel on statistical requirements for policy in an aging society and professor emeritus of health policy and management at the School of Hygiene and Public Health of Johns Hopkins University; and Jack Cornman, executive director of the Gerontological Society of America.

We welcome you both to the hearing. We have statements which have been prepared by you for the hearing, which we appreciate very much. The statements in their entirety will be made a part of the record, and we would encourage you to make such summary comments and statements from the written testimony as you care to make.

We appreciate you being here.

Mr. Shapiro, you may proceed.

TESTIMONY OF SAM SHAPIRO, CHAIRMAN, PANEL ON STATISTICAL REQUIREMENTS FOR POLICY IN AN AGING SOCIETY, AND PROFESSOR EMERITUS OF HEALTH POLICY AND MANAGEMENT AT THE SCHOOL OF HYGIENE AND PUBLIC HEALTH OF JOHNS HOPKINS UNIVERSITY;[1] AND JACK CORNMAN, EXECUTIVE DIRECTOR, GERONTOLOGICAL SOCIETY OF AMERICA[2]

Mr. Shapiro. Thank you, Senator. I do want to thank the subcommittees for the opportunity to participate in today's hearings. But before I start with my summary comments, I want to remark that I was very pleased to hear in Senator Grassley's opening statement that the inventory of data sets related to health of the elderly will be published as part of the report of these hearings.

This inventory was prepared by the panel you identified a moment ago, Mr. Chairman. It is the most comprehensive document available today on national data systems that produce information on the health of individuals, health care expenditures, services provided, and health care resources. The inventory, I am sure, will be indispensable to many groups, Federal and State government agencies, congressional committees, voluntary organizations, many academic institutions and researchers who are increasingly contributing to an understanding of our aging society.

Our panel is now preparing recommendations which will be available later in the year. At this point, I can talk about a number of the assessments concerning data needs that reinforce what has already been presented in today's hearings. Their particular value is that they reflect the consideration of a panel of scientists from many fields, all of whom are expert in data required for developing health policy.

We know that far-reaching changes have taken place in the size and composition of the aging population. We also know that the aging are a very heterogeneous group, subject to major changes in life circumstances and health care needs and costs. A major question, as we heard earlier today, is whether the increases in life expectancy we are now experiencing are associated mainly with prolongation of dependency and major increases in health care expenditures or with additional years of independent functioning.

This is extremely important for projection of needs among the aging for health care personnel, hospital and nursing home beds, and home care services. We could be led astray by assuming that the aged of the future are simply the same as the aged of today, except that there are more at the oldest ages.

A starting point would be information on what is happening today. We need to know, for example, the extent to which older persons remain in good health and the changes that occur as they move from the state of health to another, whether this marks an improvement or progressive loss of function leading to disability, dependency, and, ultimately, mortality.

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[1] See p. 42 for Mr. Shapiro's prepared statement.

[2] See p. 56 for Mr. Cornman's prepared statement.

This type of data requires repeated observations on the same individuals over time, that is, longitudinal information. Such information would throw light on the magnitude of health care and social needs of a particularly vulnerable group among the aging, that is, the long-term care patient. A common phenomenon is the exhausting of their life savings and dependency on Medicaid to meet continuing health care expenses.

The context for much of the interest in data on the aging has been the concern about high health care costs and the prospects of even greater costs as the numbers and age composition of the aged change. But increasingly, the steps that are being taken for cost containment raise questions about quality of care. Measures of quality of care need further development, but a significant start can now be made in determining whether professional standards for the process of care—that is, what is done to and for the patient and how it is done—are met, and whether the outcome of care is favorable in terms of health status or maintenance of desirable and achievable levels of health.

We are fortunate in the United States in having national information systems that have already produced useful information for health policy and planning purposes, and, with adequate funding and coordination, could provide a sound basis for meeting many of the data needs you have heard about this morning.

Some of the steps required can be summarized as follows: Link information collected in national surveys to the administrative records of Social Security Administration and HCFA while protecting the confidentiality of the individuals involved; develop longitudinal information on changes in health and personal circumstances predictive of transitions to different levels of dependency or independent living; increase sample sizes in surveys to overcome the present restrictions in assessing conditions related to those 85 and over; reach agreement on uniform definitions and classification schemes; conduct methodological research to improve the tools we have to forecast changes in the functional status of the elderly and their health care use and expenditures; adopt procedures to assure timely availability of the information; and provide a mechanism for continuous review of data needs, setting priorities and increasing the likelihood that the information will be produced.

As I indicated, later this year, specific recommendations that flow from many of these considerations will be available, and I hope there will be a further opportunity to make a presentation on these recommendations.

Senator COCHRAN. Thank you, Professor Shapiro, for your testimony.

Mr. Cornman, you may proceed.

Mr. CORNMAN. Thank you. I will try to briefly summarize the three major points in my testimony. Those points are: One, the importance of statistics in an aging society; two, the effects of past budget cuts on Federal data collection programs; and three, some recommendations to move us toward a statistical policy in an aging society.

As previous witnesses have testified, with the aging of our population, our society is moving into some uncharted waters. Those who question the vitality and overall progressiveness of our society should be reminded of the fact that more people are living longer is a great success story, the result of successful investments made by past and present generations in research, education, public health, and economic growth.

But with success comes new challenges and need for new data to help shape our responses to those challenges. As we have heard on numerous occasions already today, the most striking occasion of the need for new data is the rapidly growing population of persons aged 85 and over. Not too many years ago, there was little need to collect data on that age group.

Not surprisingly, Federal data collection programs already have been affected by reductions in Federal budgets and can be severely damaged if the Gramm-Rudman-Hollings mechanism ordering the broad sequestering of funds is triggered.

Because many of society's members are users of Federal statistics and because of the cutbacks in Federal data programs, the Gerontological Society created a special task force in 1983 to monitor trends in Federal programs collecting data on aging. In December of 1984, the Society published a report on the cutbacks that these programs had experienced through the period 1980 through 1984.

Today, we are releasing an update of that report, which concludes that while 1985 was not a good year, it was somewhat better than the previous 4 years. It also notes that the future is, at best, uncertain, given the potential impacts of the Gramm-Rudman-Hollings Act or however Congress decides to reach its deficit targets.

The two reports document the three approaches to cutting back data collection programs. Those are: One, reducing the number of people surveyed; two, increasing the time between surveys; and three, reducing professional staffing.

Each of these approaches has serious implications for the utility of the data collected. Reductions in number of people surveyed to need single size is too small to analyze data for particular groups of people. For example, because of such a reduction, there are too few cases included in the National Health Interview Survey to describe the active life or health of life of 85 and moreover, who happen to be the major users of health care services in the country.

Increasing time between surveys means policymakers will have to work longer with data and wait longer for current information. Again, for example, with the National Nursing Home Surveys, now to be conducted every 8 rather than every 4 years, we will have no data from this survey on the impacts of a prospective payment system for reimbursing hospitals until 1987.

Finally, cutbacks in hiring young professionals to be trained to manage the Federal Government data collection programs threaten the future utilities of these programs. Because universities cannot run training programs for managers of these programs, on-the-job training over a good number of years is the only way to develop tomorrow's data program managers and professionals.

Yet, because of personnel ceilings, staff reductions, and uncertainty about Federal employment, young professionals are being neither attracted nor hired to work on these programs. Looking ahead, the society would like to offer three general recommendations: First, Congress must not leave the future of data collection programs to the less than tender mercies of the Gramm-Rudman-Hollings Act. With the reductions already experienced, further cuts would diminish seriously if not destroy the usefulness of many of these data bases.

The society therefore urges Congress, at a minimum, to resist any further cutbacks in Federal data collection programs relating to the aging of our population unless thorough, professionally evaluated studies show that a cutback would not damage the creditability and the utility of the data source.

We were, in fact, tempted to recommend a flat rejection of any further reductions in these programs, but we do realize some nondamaging savings might be achieved through better coordination of the agency collecting the data, which brings me to our second recommendation: The society strongly supports the creation of the interagency forum, which has been discussed before, and of the proposal to create statistical centers on aging in the Bureau of the Census and the National Center for Health Statistics, and we hope that the National Institute of Aging would also be involved with our sector to help coordinate and bring the results of research in aging to these centers.

We do, however, have one strong caveat in making that recommendation: These centers should have formal advisory committees composed of nonexecutive branch users of the data to help identify critical information needs and help assure the data produced will be in the most useful form. By users, we mean researchers, policy analysts, policymakers, including representation from Congress.

Further, these centers could be viewed as models, which, if successful, could be adopted to coordinate data programs relating to other subpopulation groups, in particular, in my view, for children. By way of example of how outside advisers can assist Federal data program planners, I have submitted for the record the list of recommendations that the society prepared for the 1990 census.[1]

I will not review those recommendations now other than to note that the Bureau has been most responsive to those recommendations by including some of them in the pretest of the 1990 census.

I urge your subcommittees to review and to transmit your views on those recommendations to the Bureau. Finally, we recommend that Congress authorize steps which would allow these data programs to attract and hire the young professionals who will become tomorrow's managers of these programs. Two possible approaches, both difficult, but perhaps we can work them out, would be to provide some flexibility in personnel ceilings to allow the hiring of young prefessionals and provide these young professionals some degree of job security.

In summary, the society welcomes the interest of these two subcommittees on this issue of statistical policy for an aging society. While much of today's society has focused on the needs relating to the elderly, I hope we will all not forget that an aging society includes people and children of all ages across the life course.

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[1] See p. 158.

It is important that the statistical foundation for our laws, policies, regulations, and planning be maintained and improved for all age groups. Many of the charts and figures and projections presented today could well be changed for the worse if we do not respond also to the needs of the 25 percent of our children now living in poverty.

I urge this subcommittee to continue their interest in this topic. The best laid plan for coordination can fail for lack of adequate political support and for lack of adequate funding.

Thank you very much.

Senator COCHRAN. Thanks, Mr. Cornman.

Let me simply respond at this point to the concern expressed about the across-the-board reductions that might be required under the Gramm-Rudman-Hollings Act. I couldn't agree more with the concerns that are mentioned, and I think most in the Senate share that view, that a maximum effort needs to be made by the Senate to help ensure that the deficit targets are reached through the budget and appropriations process so that there won't be an across-the-board sequestration under that law.

To me, that would be catastrophic and an abrogation of our responsibilities as legislators if we permitted that to occur. So I speak not just for the benefit of this program and this effort that we are discussing here today, but many other program activities which would be devastated by a sequestration.

From your testimony, I understand we are going to be getting a report. Professor Shapiro mentioned a report that is going to contain recommendations. Do you think this report would be a good working document for the interagency forum as it goes about the task of identifying ways that the agencies can work together?

Mr. SHAPIRO. One of the very happy developments over the last few months, from the standpoint of the panel, is the holding of the summit conference. The projected interagency forum and the two centers mentioned here this morning represent a parallel activity to what we at the panel have been carrying out. From a timing standpoint, it is absolutely perfect.

I hope that not only our recommendations, but the material we are developing that discuss fully the basis for the recommendations will become an exceedingly important working document for this interagency group.

Senator COCHRAN. Will you make available a copy of your recommendations to our committees? We would be anxious to have it.

Mr. SHAPIRO. We would be delighted to.

Senator COCHRAN. Thank you very much for that.

Has your panel identified overlaps and gaps in the data systems that have been reviewed? I know that there is a compilation or an inventory of data systems that has been undertaken by the panel. Can you tell us anything about that?

Mr. SHAPIRO. The issue of overlap is an extremely important one, which our panel is in the process of addressing. As I see it, however, the problem of overlap in no way compares in importance to the need for the types of information that are already being produced and the improvement and enhancement of the information systems that are necessary.

I do not believe the question of overlap is an urgent one. However, the interagency committee or forum will certainly want to address that area, as will our panel. And to the extent that we do find overlap that might be dealt with, the subject will be considered in the report we are preparing.

I just want to emphasize that I do not see a major issue at this point in the question of overlap.

Senator **Cochran**. Mr. Cornman, in connection with the overlap and gaps issues, do you have any comments about the focus of the forum or the panel that Professor Shapiro is describing?

Mr. **Cornman**. Only in general. I would leave it to their expertise as far as the question of overlap. Our studies have just tried to look at what has been going on in losses of data, not at the overlap and gaps. I think, though, that from a credibility point of view, a point of view of using what resources we have, efficiencies that are possible, we certainly should look at overlaps as a way of making our program more efficient.

I would also, though, reemphasize that we sometimes spend too much time looking at a very small tree in blowing forests. I am not sure we should spend too much time looking at overlaps if it is not as serious as he says it is.

Senator **Cochran**. What role do you see, if any, for your organization in relationship to the forum or the panel's work?

Mr. **Cornman**. We would love to give you advice that you will accept. [Laughter.]

The Professional Society of Researchers and Educators in Gerontology would be pleased to cooperate in any way we can, in suggesting names or as an organization, being involved in advisory committees if that might be suggested. We will play a role in either of those senses, as an institution or as suggesting people that we think would be useful members of the panel.

Senator **Cochran**. In your previous statements, you've mentioned a phrase. You talk about "intergenerational equity". I was thinking about standardization of definitions, and I wondered what your definition of that might be.

Mr. **Cornman**. We have a long report on that subject, which I think we sent you a copy of. Generational equity is not a term that I think you can define. We have problems; we have needs; we have challenges to respond to, and we should respond to those, and we should create opportunities for people of all ages.

When you get into a discussion of intergenerational equity, you find yourself in a terrible data bind, a measurement bind that I think leads you nowhere except to a dead end.

So I don't think there is a definition.

Senator **Cochran**. I remember hearing, in my southern religious background, a minister used as a text for a sermon one Sunday, "The age you are is the best age there is." [Laughter.]

It was a wonderful discussion.

Mr. **Cornman**. I think along those lines, somebody said once there was a survey done that old age begins always 5 years later than whatever your age was.

Senator **Cochran**. But it is an attitudinal concept. I guess it is constantly changing for us, the older that we get.

Mr. CORNMAN. It is like seniority; the longer you get it, the better it is.

Senator COCHRAN. Yes, I like it a lot better this year than I did last year. [Laughter.]

Well, this has been a very interesting hearing. I regret that I was not able to be here at the beginning of the hearing, but I appreciate Senator Grassley chairing the hearing and getting us underway and off to such a good start. I think this has been very helpful to us, and I hope that it turns out to have a constructive impact on policy and legislation. I think it will.

Thank you all for participating. The hearing is adjourned.

[Whereupon, at 12:03 p.m., the subcommittees were recessed, to reconvene subject to the call of the Chairs.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Statement

By

Manning Feinleib, M.D., Dr.P.H.

Director

National Center for Health Statistics

Public Health Service

Department of Health and Human Services

before the

Senate Committee on Labor and Human Resources

Subcommittee on Aging

and the

Senate Committee on Governmental Affairs

Subcommittee on Energy, Nuclear Proliferation, and Government Processes

June 3, 1986

Good Morning Senators Cochran and Grassley and members of the Committee. I am Manning Feinleib, M.D., Dr.P.H., the Director of the National Center for Health Statistics (NCHS). I am pleased to describe the efforts of the NCHS to collect and disseminate data on the health of the aging and their use of care.

Drs. Keane and Williams have described the Interagency Forum on Aging-Related Statistics, which will provide a focus and mechanism for further collaboration on aging statistics among Federal agencies. I look forward to the Center's role as co-chair, and the opportunity to gain maximum input in developing our data collection in order to increase the relevance of our data for research and policy analysis. This Forum also provides the opportunity to collaborate on issues of record linkage, standard items, and special analyses. NCHS has had experience over the last few years with interagency coordinating committees with several agencies within the Public Health Service, and we have found such collaboration to be of great value. The Forum has the same potential for the area of aging-related statistics.

I would like to describe five of the Center's activities in producing statistics on aging and some opportunities we have to make contributions to our collective knowledge on the health of the nation's aging population.

A recent and major activity of NCHS is producing longitudinal data--that is, data about the same older persons collected over a period of one or more years. The importance of longitudinal data is that we can identify changes over time as a person goes from the onset of a chronic disease, to possible disability, to the use of long term care (LTC), and to eventual death. The impact of major events such as retirement, moving the household, and death of a spouse on the health of the aging can also be identified. A primary method for collecting this data is the followup of respondents to NCHS surveys.

We are currently conducting the NHANES I Follow Up Survey, recontacting respondents to the 1971-75 National Health and Nutrition Examination Survey (NHANES) to identify risk factors for disease as well as factors in the aging process which contribute to independent living. The 1986 Longitudinal Study on Aging (LSOA) recontacts those persons aged 70 and older who were interviewed two years ago in the 1984 Survey on Aging (SOA). This longitudinal study is of importance for identifying changes, both positive and negative, in the ability of older persons to perform everyday activities. We will gain insight on how these changes, coupled with assistance from the family and from community services, influence admission to nursing homes and longevity. Both of these longitudinal surveys follow older persons into nursing homes and other LTC institutions, and were results of collaboration with and funding from the National Institute on Aging (NIA). Finally, we are in the process of conducting the 1986 National Mortality Followback Survey, which is obtaining data about health and the use of care in the last year of life of persons who died in 1986. Information is being obtained from the families of these persons, and will include data on risk factors for mortality and health service use prior to death.

There is the potential of using some of the Center's other surveys as the basis for longitudinal data collection. We have been discussing with NIA the possibility of recontacting the families of nursing home residents in the 1985 National Nursing Home Survey to learn about subsequent discharge and readmission, use of hospital care, and changes in functioning. This longitudinal data will provide insight into the entire episode of care as well as data on aspects of catastrophic health costs.

The potential also exists to follow up the older persons in the 1986 LSOA at two-year intervals and to expand the follow up to include persons younger than age 70 to examine the precursors to retirement and to possible disability. NCHS is also planning for a National Health Care Survey, a restructuring of several existing surveys of health care providers. This survey, if fully implemented, will allow for greater coverge of long-term care providers and provide for the followup of patients, allowing us to address outcomes of care.

A second major activity of NCHS that is important to health data about the aging is record linkage. The linkage of survey data with administrative records provides an approach to expanding our longitudinal data that is highly cost-effective. With the support of the National Institutes of Health (NIH), NCHS has developed the National Death Index (NDI) which provides a mechanism for determining if a survey or research subject has subsequently died and the cause of death. The NDI is being used in all the Center's surveys on the aging and in various research activities of the NIH. Information on death and its cause provides insight into the factors related to the risk of disease and to prognosis. Another example is our effort to link data from our surveys to Medicare administrative records on the use of health care to increase our knowledge of the course of certain medical conditions and their resource implications. An example of this type was the linkage of NCHS' 1980 National Medical Care Utilization and Expenditure Survey with Medicare and Medicaid records. Linkage of Medicare records to the 1986 LSOA and the Follow Up to the 1971-75 NHANES (two longitudinal surveys I mentioned earlier) would be useful, and we are currently discussing potential linkages with the Health Care Financing Administration. The facilitation of record linkage, while protecting privacy and confidentiality, is a key initiative for statistical policy. From our initial discussions, it is likely that this topic will be a major focus of the Forum.

A third activity is assessing the feasibility of expanding the coverage on the 1988 NHANES to include persons aged 75 to 84. The NHANES is unique in that its source of health data is a physical examination and clinical and laboratory tests. Until now, this survey has excluded persons over the age of 74, mainly because of their high rate of refusal to participate. We recognize, however, that such data are important to identifying the impact of disease on the functioning of older persons. We are now reviewing the potential of expanding coverage to the older ages by:

- examining the feasibility of conducting a limited physical examination in the respondent's home or in a mini-van which can be parked nearby.
- developing a physical examination and clinical evaluation to assess the functioning of older persons and the factors which may lead to deterioration.

- determining an approach to measuring cognitive deficits in older persons. NCHS is planning a workshop on measuring cognitive impairments and physical functioning of older persons. Measurement of cognitive impairments is extremely difficult. Yet, it is important to our understanding of the prevalence of Alzheimer's Disease and the ability of older persons to live independently in the community.

The fourth activity is methodological work in measuring the health of older persons. Progress is underway in several areas. There is concern over the quality of information older persons provide in interview situations. Reduced concentration, memory loss, and other cognitive deficits become more prevalent with age. It is often difficult to tell whether the replies of an older respondent to certain types of questions are of adequate quality or whether information should be collected from an informant. NCHS recently has established a Questionnaire Design Research Laboratory, in which we can address such measurement issues. Because these issues are just as relevant to conducting research and collecting demographic data, there is the potential of collaborating with the NIA and the Bureau of the Census. Methodological research can identify the optimal procedures for eliciting various types of information from older persons themselves or their informants.

NCHS is planning for an international conference on measuring the health of older persons. The objective is to develop collaborative research efforts on measurement issues by bringing United States and international experts together at a conference. A cross-national exchange on the state-of-the-art which generates collaborative research can provide an opportunity to improve the scope of data collected on the health of older persons and its quality as well.

As longevity increases, the quality of life is becoming a major concern not only to older persons and their families, but also to the public health community and to policy makers. We have attempted to measure quality of life in a basic way in the Follow Up to the 1971-75 NHANES and the 1984 SOA. The definition of quality of life for older persons is elusive, and its measurement is problematic. The Center has the potential for addressing these issues in a planned project to examine quality of life throughout the life course.

The fifth major activity of NCHS is analysis and dissemination of the data. Intense interdisciplinary collaboration is critical to the establishment, maintenance and use of data systems about the health of older persons. It has been observed that an analyst cannot effectively study pigs one day and pig-iron the next. Similarly, analysis of health data on the aging requires specific qualifications. Expertise in geriatrics and medical care must be melded with the background of the survey professional in statistics, social science, and policy analysis. NCHS has conducted special analyses of importance to researchers and policy makers. Some examples are the reports on: trends in mortality, use of health services by elderly women, elderly who live alone, those who need home care, and (forthcoming) elderly with urinary incontinence. We are collaborating with the NIA to develop a new report on statistics on aging, which will be produced on a periodic basis. This report is aimed at researchers and policy analysts alike and will contain data by detailed age categories. Another collaborative effort with NIA is the preparation of a computer tape of trend data on health and the use of care from the National Health Interview Surveys conducted from 1969 to the present. This data will provide maximum flexibility for researchers in analyzing trends and special subgroups of the elderly.

There is potentially far more knowledge of value to be gained through the analysis of an agency's statistical output than could possibly be extracted by its own staff. The Center has given special attention to the timely release of public use tapes while maintaining confidentiality. It has conducted several conferences to provide technical assistance to data tape users. There is the potential for focusing a conference on the needs of researchers interested in data on aging. It is only by making tapes widely available to the public and providing assistance in their use that we reap the full benefits of our statistical activities.

In summary, I believe we can greatly improve the relevancy and availability of health data on the aging through increased collaboration among the agencies represented on this panel as well as with many others. I will be pleased to answer any questions you may have.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration
Refer to
Baltimore MD 21235

FOR RELEASE ONLY UPON DELIVERY

STATEMENT

BY

JANE L. ROSS

DIRECTOR, OFFICE OF RESEARCH, STATISTICS
AND INTERNATIONAL POLICY

SOCIAL SECURITY ADMINISTRATION

BEFORE THE

SENATE COMMITTEE ON GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON ENERGY, NUCLEAR PROLIFERATION,
AND GOVERNMENT PROCESSES

AND

IATE COMMITTEE ON LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON AGING

JUNE 3, 1986

Mr. Chairmen and Members of your Subcommittees. I am Jane Ross, Director of the Office of Research, Statistics, and International Policy in the Social Security Administration. It is a pleasure to be here today to discuss information needs relating to the aged population.

The Social Security Administration welcomed the convening of the May 2 summit meeting of Federal agency heads to discuss mutual information needs relating to the aged. With so many agencies involved in collecting data about the aged and in operating programs to assist them, and with the need we all have to use scarce resources as effectively as possible, it is essential that we have a mechanism to ensure that data gaps are filled and that we avoid duplication of effort. We believe that the summit meeting and a continued forum are positive steps that will help ensure progress toward our goals of cooperation and coordination.

We share the enthusiasm being expressed by others here today about the potential for more collaborative efforts. For example, we believe that with relatively minor modifications to questionnaires, some of the surveys planned by one agency can be tailored to meet the information needs of others. The continuing forum will provide us all with a means to be more aware of one another's survey activities and to facilitate their design in ways that help ensure that the data they collect will be as widely relevant as possible.

We also support the call for maximum use of linkages between data files. Our own administrative record system includes a wealth of information about Social Security beneficiaries and workers covered by Social Security; other agencies also have valuable administrative files. Linking these files to each other and to survey data sets--always with the strictest regard for confidentiality concerns--increases their usefulness exponentially.

Further, we welcome the inclusion of the heads of operating agencies, of policymakers, in subsequent interagency discussions to determine priorities among data needs. The proposed mix of data collectors, researchers, and users of information helps ensure the relevance of all of our information gathering activities. In particular, we would suggest occasional seminars involving that same mix of participants to discuss what is known and what needs to be learned about specific topics.

In summary, we at Social Security have benefited already from participation in the informal meetings of the forum that preceded the summit meeting and from the summit meeting itself. We are confident that further cooperative and collaborative efforts will strengthen and improve the focus of our own statistical and research activities as well as those of the other participating agencies.

I would like to turn now to a brief discussion of some ongoing activities of the Social Security Administration that pertain to the aging of our society and that relate to the interests of some of the other agencies represented here today. Specifically, I would like to discuss work in progress to assess the economic status of the aged now and in the future and to analyze the work capacity of older persons and the demand for the services of such workers.

Economic Status of the Aged. SSA conducts its own occasional surveys and uses the recurring surveys of the Census Bureau to assess the economic well-being of the aged and trends over time in their economic status. For example, we recently conducted a New Beneficiary Survey, which interviewed 18,600 retired and disabled workers and their spouses and widows in 1982 to gather information on their income, assets, health status, work and marital histories, and retirement decisions. The NBS enables us to examine in detail the economic status of current retirees and to compare their economic status to that of a cohort of new retirees surveyed a decade ago by the SSA.

SSA researchers also are using the Census Bureau's Current Population Survey and Survey of Income and Program Participation (SIPP) to assess the income and wealth of 5-year age groups within the aged population and to track the incomes of aged cohorts over time. Newly available data from the SIPP, especially, enable us to undertake a much more comprehensive assessment of the overall economic status of the aged than was previously possible because of the SIPP's emphasis on gathering reliable data on asset holdings and asset income.

Further, our publications include the popular Income of the Population 55 and Over, a data book that provides a wealth of information about the amount and sources of income of the aged. We also publish monthly a Social Security Bulletin and an annual Statistical Supplement to the Bulletin containing more than 200 tables providing information on Social Security benefit payments and beneficiary characteristics.

We also understand that others are contemplating a reinterview of those previously involved in SSA's Longitudinal Retirement History Survey, which tracked a group of persons approaching retirement over a 10-year period beginning in 1969. A reinterview of that sample would provide valuable insight into what happens to the income of older persons as they age and into the economic status of the very old--those now entering their 80's.

Work Capacity and Demand for Older Workers. There is much interest in how increases in life expectancy will affect workers' willingness and ability to work. We are also interested in finding out whether demand for the services of older workers will increase as the pool of younger workers shrinks. Several of our research activities relate to these interests.

For example, we are analyzing data from the National Health Interview Survey, sponsored by the National Center for Health Statistics, to determine trends in the health status and work capacity of older workers. A better understanding of recent trends in health status and work capacity will help us determine whether projected increases in longevity will be accompanied by an extension of active worklives.

In addition, we have funded the coding of data from the NIH Framingham Heart Study, a 34-year series that collected health data on the residents of that Massachusetts town. Analyses of those data will shed light on why some persons with an impairment quit working while others equally impaired continue to work. Another project is using data from the New Beneficiary Survey to analyze the relationship between the decision to retire and a person's occupation and health status.

SSA also is sponsoring a grants competition to encourage extramural researchers to investigate further the relationships between improvements in longevity and ability to work, the factors that are most likely to affect the future work ability of older persons, and the relationship between the industry or occupation in which a given person works and his ability to continue working up to or past age 65. The grants competition also is encouraging extramural researchers to help us better define and measure the concepts of "ability to work" and "physically demanding jobs." Operational definitions of these terms will help us better project the work capacity of older persons in the future.

Whether older workers will be willing to work longer as they live longer is another research issue. Before projections of the future can be made, better understanding is needed of past trends. A project we plan to do in-house will examine trends since 1960 in retirement using data both on labor force participation and on the ages at which Social Security benefits are first claimed.

Whether older workers will work longer also is a function of the demand for the services of older workers. Many private pension plans, for example, provide no incentives for older persons to continue to work. These pension plans pay full benefits at age 62 and/or give no credit in pension calculations for work after age 65.

Further, the results of a recent grant sponsored by SSA suggest that few employers now offer incentives to keep their older employees working. This may change as the supply of younger workers diminishes. SSA is funding further analysis of how private pension systems and employers may respond to the changing age structure of the labor force.

Many of the topics I have outlined complement and will utilize the ongoing work of the National Institute on Aging, the National Center for Health Statistics, the Census Bureau and others. We at the Social Security Administration look forward to collaborative efforts among us as we pursue common research interests.

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Testimony for the U.S. Senate

Subcommittee on Energy, Nuclear Proliferation
and Government Processes

Subcommittee on Aging

"Statistical Policy for an Aging America"

June 3, 1986

Senator Cochran, Senator Grassley, members of your Senate subcommittees, I want to thank you for the opportunity to participate in today's hearings on Statistical Policy for An Aging America. I am Sam Shapiro, Professor Emeritus of Health Policy and Management at the Johns Hopkins University School of Hygiene and Public Health; previously I was, for many years, Vice President and Director of Research and Statistics at the second largest HMO in the country, the Health Insurance Plan of Greater New York.

The specific topic I will deal with is concerned with needs and gaps in policy relevant information that can be filled by national data systems. I approach the subject on the basis of a long history of health services and epidemiolgical research on issues affecting the aged, as an extensive user of health statistics from Federal Agencies for policy analysis, and as chairman of a panel of distinguished scientists on Statistics for An Aging Population - Requirements for Health Policy, a title that reflects a close correspondence with the concerns of your subcommittees.

This Panel was established by the Committee on National Statistics of the National Academy of Sciences' National Research Council, with support from the following Federal agencies: the Office of the Assistant Secretary for Planning and Evaluation, DHHS, the National Center for Health Statistics, National Institute on Aging, National Institute of Mental Health, Health Care Financing Administration, Social Security Administration, and Veterans Administration. The Panel has been focusing on three sets of objectives:

(1) to determine the data needs for development of health care policy for an aging population during the next decade and to recommend actions to correct major shortcomings in the available data;

(2) to determine whether changes or refinements are needed in the statistical methodology used in health policy analysis and recommend actions or further research; and

(3) to identify the essential components of a statistical system that would provide adequate data on aging for all functional areas and recommend changes in the decentralized federal statistical system what would facilitate integrating data from the various system components.

To obtain the broadest possible advice, the Panel sponsored analyses by 12 experts of the issues involved and a Symposium that provided an opportunity for users of Federal statistics with research, policy, and program interests to exchange views on the results of these analyses. The Panel is now preparing its report which will include assessments of critically important data needs and recommendations to fill existing gaps. The recommendations will not be available until later this year, but assessments that will shape them and the opportunities for meeting needs by strengthening our Federal statistical systems are clear at this time.

The context is the far-reaching changes that are occurring in the social, economic, and demographic composition of the nation; in the increased life expectancy; in the structure of the health care delivery system; in the costs and financing of health services; and in federal, state, and local health care programs. Data will be needed to understand how these changes alter the kinds and amounts of health care Americans use, how costs for health care are met, and how quality of care and quality of life are affected. What we learn will provide the means for judging the extent to which health policies adopted are meeting their objectives and whether modifications in existing policies or new policies are needed.

These issues have special relevance for the aged. This is the segment of our population that will be experiencing the most profound changes in size and composition over the next few decades and that will continue to be a focal point in federal and state health policies aimed at containing health care costs.

It is well known that the outlook is for substantial increases in both the number and proportion of the population aged 65 and over, with those at advanced ages of 85 and over experiencing the most pronounced increase. By now, it is also recognized that the aged are a very heterogeneous group, subject to major changes in life circumstances and health care needs. As a result, a common thread binding all considerations of requirements for data is that information should be available for successive age groups, starting with those 65-69 or 65-74 years of age and ending with the advanced age group 85 or 90 and over. The need is two-fold: routine provision of greater age detail in statistical series and changes in the design of sample surveys to assure the inclusion of adequate numbers of persons at the oldest ages for analysis. The topics I will be discussing illustrate the importance of not treating the aged stereotypically but as consisting of age subgroups, each of which shows great diversity.

Health Status

It has already been noted that a major factor underlying the demographic change among the aged is increased life expectancy. The question that has been debated is whether increases in longevity will be associated mainly with prolongation of dependency and major increases in health care expenditures or with additional years of some degree of independent functioning life.

We cannot answer this question convincingly. Federal statistics have documented the changes in life expectancy but there is little national data showing whether and how the period of independent functioning has also changed. The limited data available have been used to support two opposing views; (a) as mortality decreases, morbidity will also decline, and (b) the increased life span, particularly at advanced ages, will not be accompanied by decreased morbidity and this may result in dramatic increases in the need for prolonged expensive health services (i.e., management of chronic or diabling conditions over more years of life).

To deal effectively with this issue, we need new approaches to the development of measures of physical, cognitive, emotional, and social functioning. Several measures are available and have been used in national surveys. These need to be improved and broadened to take into account the positive or successful aspects as well as the negative aspects of aging and to reflect ordinary behaviors and activities of older persons which indicate their quality of life and affect their relationships with those close to them.

Despite the physiologic losses and psychosocial stresses often associated with advanced age, many elderly individuals have the vitality and resilience to function at a high level or to recover and function independently, once again, following a disabling condition. Data are needed that measure the extent to which older individuals remain in good health and the changes that occur as they move from one state of health to another, whether this marks an improvement or progressive loss of function leading to disability, dependency and, ultimately, mortality. This requires repeated observations on the same people over time, i.e., longitudinal information on both the well and the impaired in the population.

Health Services Utilization and Costs

Health status, acute and chronic conditions, and levels of physical and mental impairment or disability are well know determinants of demand for health services among the aged as they are at younger ages. But, the timing, frequency, intensity, and sources of care that are utilized, and the associated costs, are influenced by other factors that are especially important for the aged. These include the types of services covered by Medicare, regulations designed to contain costs, as in the case of the current prospective payment system (PPS) for Medicare hospital stays; and policies that affect the supply of and access to alternative sources and types of care, most prominently those that can effectively replace institutionalization. Large roles are also played by many personal circumstances such as living arrangements, availability of informal sources of care, financial resources, and insurance supplemental to Medicare. Further, changes are occurring in the structure of health services delivery systems, e.g., the rapid growth of health maintenance organizations, that have the potential for changing the utilization patterns of the general population and the elderly.

In short, we are in a highly dynamic period which from all indications will continue for years. Measures of the effect of changes on utilization and costs as age advances are needed on a continuing basis to determine whether policies require adjustments. In some instances, this calls for technical advances such as the introduction of severity of illness measures when applying PPS for reimbursement of hospital episodes. Longer term public policy and private initiatives in the health field require estimates of future needs among the aged for health care personnel, hospital and nursing home beds, and home care services. The quality of these projections is dependent on the availability of data from many sources that measure the relationship between the conditions referred to above and health care use and costs.

Long-Term Care

"Long-term health care refers to the professional or personal services required on a recurring or continuous basis by an individual because of chronic or permanent physical or mental impairment. These services may be provided in a variety of settings including the individual's own home." This is the definition advanced in 1980 in the report, Long-Term Health Care Minimum Data Set, issued by the National Committee on Vital and Health Statistics.[1] Other definitions exist but all have two elements in common; care over an extended period and loss in some capacity for self-care. Accordingly, long term care patients require the help of another person in performing every day activities; they are frequent users of a broad variety of health care, social services, and residential facilities; and expenditures of public and private funds to meet their needs is very high.

The aged are the most vulnerable group in the population for long-term care. How they fare is heavily influenced by social and family networks which could serve as informal sources of support, the type of facilities for home and institutional care available in the communities, and the existence of mechanisms to coordinate medical and social services. Financial resources are important from a public and private standpoint, e.g., a common phenomenon among the aged is exhausting life savings and becoming dependent on Medicaid to meet continuing health care expenses.

These conditions are not static. They are undergoing changes partially due to what has been learned from demonstration programs, policies that have already been adopted, and the changing demographics among the aged. Data are needed to measure these effects and determine future requirements. One of the most pressing needs is for longitudinal surveys to provide more complete information concerning changes the aged experience in their use of different levels of care. This would go a long way to meeting data needed in planning how to reduce the financial impact of long-term care, and identifying conditions that make financing of insurance coverage of institutional and non-institutional care feasible.

Quality of Care

I want to turn now to the subject of quality of care assessment and deal with it more fully than the previous topics because of the prominance it is gaining after a period of relatively minor attention. The Office of Technology Assessment, in a recent report[2] points out that "Medicare's prospective payment system (PPS) has intensified concern with the complex relationship between cost and quality of medical care" and that "assessing PPS impacts on quality of care is critical.....". Among the reasons given is that if PPS succeeds as a cost containment strategy, "its effect on the quality of care will be a deciding factor in the program's continual survival." In another report[3] the Institute of Medicine focuses attention on the importance of information systems for assessing and improving quality of care of nursing home residents and recommends that the Secretary of the Department of Health and Human Services "undertake a study to design a system of acquiring and using resident assessment data."

These reports reflect the emergence of quality of care as a matter of central interest for policies directed at controlling costs or improving services for specific subgroups of the aged. As questions arise about the short-term and long-term influence on quality of care of policies that have been adopted or are being considered, the need for measures of quality will become more intense and will cut across all of the aged.

The most widely accepted framework for assessing quality of care consists of three components, structure, process, and outcome.[4] Briefly, structure refers to professional personnel, physical facilities, and medical technology; process refers to what is done to and for the patient or defined populations and how it is done; and outcome refers to changes in health status or maintenance of desirable levels of health.

A comprehensive assessment of quality of care would be concerned with all three components and their interrelationships, with the ultimate measure of quality determined by the outcome of care. In practice, there are often severe constraints in linking particular structural factors and processes of care to specific measures of health status. However, knowledge has cumulated regarding the effectiveness of health care interventions and advances have been made in the development, testing and application of health status measures that are useful in examining both technical and health care system effects on the health of a population. This holds true for all age groups but is particularly relevant for the aged whose needs for health services are high and large proportions of whom could be affected positively or negatively.

Outcome measures are specified under the three functional goals of health care given below:

Caring - as indicated by reassurance and relief from anxiety, satisfaction and communication between provider and patient which may affect whether regimens prescribed are followed and response to symptoms and care seeking are appropriate.

Curing and Maintenance - reduction in symptoms and dependency; avoidance of complications and iatrogenic effects of treatment and reversing the effects when they occur; improvement or stabilization in functional capacity; reduction in avoidable mortality. Many specific conditions are candidates for observation; e.g., hypertension, angina, hip fractures, major depression, glaucoma, cataracts, hearing, visual and dental defects, respiratory diseases.

Prevention - primary, secondary, tertiary prevention measures designed to prevent, delay or reverse the progression of disease, reduce functional limitations, handicap or dependency due to health conditions. A preventive measure may be interpreted as a surrogate or intermediate outcome measure when its effect on a health condition or health status has been establshed, when it reaches the population that is at risk and can benefit from it, and when there is appropriate follow-up. Prevention procedures that could serve as indicator of quality of care include examination and follow-up of asymptomatic individuals for many of the conditions already mentioned, (e.g., hypertension, glaucoma, and other visual defects, impaired hearing); counselling on smoking cessation, exercise, rest, diet; and rehabilitation aimed at restoring function consistant with the maximum achievable level.

I do not want to minimize the complexity of measuring quality of care or the need for substantial developmental work to refine these measures, produce new ones, and establish more firmly relationships between specific process of care and outcome of care. But, there is little question that a significant expansion in the measurement of quality of care can be achieved through the use of presently available or readily adaptable measures.

Prospects and Requirements for Producing Needed Data

National information systems that have already produced useful information for health policy and planning purposes provide a sound basis for meeting many of the data needs described. Specific recommendations that would accomplish this objective are being developed by the National Research Council's Panel on Statistics for an Aging Population. They are not yet available but several broad considerations can be stated.

The sample surveys and the vital statistics system of the National Center for Health Statistics represent the principal sources of national data on health status and utilization of health services for the population as a whole and the aged, in particular. With adequate funding, they can be adapted to meet many of the data needs identified. The Medicare data system has already established its value in connection with the prospective payment system; more can be expected through changes that effectively link reports of ambulatory and hospital care. A major strength of the system is that it can produce data for small geographic subdivisions. The Bureau of Census' Survey of Income and Program Participation can provide needed information on changes over time in income, living arrangements, government program eligibility and participation in relation to health status. The forthcoming National Medical Expenditure Survey of the National Center for Health Services Research and the Health Care Financing Administration will be an extremely important source of information on the utilization and expenditure patterns of the elderly population--both community and institutional residents.

The infrastructure for producing the data exists but major advances in their ability to do so are dependent on several changes. These include:

- linking information collected in several of the national surveys to the administrative records of Social Security Administration and HCFA, while protecting the confidentiality of the individuals involved;
- developing longitudinal information on changes in health and personal circumstances predictive of transitions to different levels of dependency or independent living through surveys and aggregating data from the Medicare files for the same eligibles over a long period of time;
- increasing sample sizes in surveys to have adequate numbers of persons at different ages and, thereby, overcome the present restrictions in assessing conditions related to those 85 and over;
- reaching agreement on uniform definitions and classification schemes for use in different data systems;
- conducting methodological research to improve the tools we have and the application of the information that becomes available, as in forecasting changes in the functional status of the elderly and their health care use and expenditures;

- adopting procedures that assure timely availability of the information for analysis by government agencies and non-government researchers; and
- providing a mechanism for continuous review of data needs, setting priorities, and increasing the likelihood that the information will be produced.

I hope there will be an opportunity to present a more explicit statement on the recommendations when they are available.

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Testimony for the

UNITES STATES SENATE

Committee on Governmental Affairs

Subcommittee on Energy, Nuclear Proliferation
and Government Processes

Subcommittee on Aging

"Statistical Policy for an Aging America."

June 3, 1986

Chairman Cochran and Chairman Grassley, I am John M. Cornman, Executive Director of The Gerontological Society of America. The Society is the national, scientific organization of gerontological researchers, educators, and other professionals in the fields of biology, clinical medicine, the behavioral and social sciences, and social research, policy analysis, and planning. Many of the members of the Society, then, both produce and use statistics generated at the national, state, and local levels, often in connection with public policy issues. However, my principal concern today is not the parochial interests of individual researchers, but the broader issue of protecting and improving the data bases on which sound public policies and many private decisions rest.

STATISTICS ARE IMPORTANT

Statistics are generally not seen as one of the more exciting areas of government policy, but they are important. Data gathered by the federal government determine Congressional representation and cost-of-living increases in the private and public sectors, influence trade policies, identify emerging problems and changes in the existing conditions, and affect allocations of federal resources for health, education, welfare, and economic development. Further, sound public policy can only be made when there is a clear understanding of the effects of past policies and the status of current conditions. This understanding depends on accurate recording of trends in all areas: demography, income, wealth, health, and housing.

TRACKING THE AGING OF SOCIETY

America is aging. The number of people aged 65 and over is expected to increase from 29 million persons today to 65 million in 2030, an increase of about 225 percent. The number of persons aged 85 and over will increase from 2.7 million today to 8.6 million in 2030, a jump of almost 320 percent. The sheer magnitude of these increases in the number of aged people coupled with the disproportionate population growth among our very oldest citizens will demand new private and public sector policies. Because the increase in the elderly population is unprecedented, decision makers need sound information about these demographic changes if they are to make effective, efficient policy choices. Most importantly, policy makers must be able to identify current and projected differences among the elderly: how do those between the ages of 65 and 75 differ from those who are older than 75 or those older than 85.

The solvency of Social Security and containing health care costs are examples of major policy decisions requiring sound data. Determining and ensuring the solvency of the Social Security system depend on accurate tracking of current and future population and income trends. Health care cost containment policies rely on accurate monitoring of current health status and expenditures; of medical treatment to learn what is working and what is not; and of the long-term health of the population to learn effects of such innovations as prospective payments to hospitals and health promotion programs.

THE EFFECTS OF PAST BUDGET CUTS

Not surprisingly, federal data collection programs have been affected by cuts in federal budgets. However, savings made through cutbacks in federal statistical programs can actually result in greater total costs, even in the short run. The Gramm-Rudman-Hollings budget cuts of 4.3 percent for 1986 mean that already-planned efforts to reduce the error in estimating the Consumer Price Index may be deferred. While this sounds like an arcane issue, somewhat akin to counting angels on the head of a pin, according to the Bureau of Labor Statistics each one percent increase in the Consumer Price Index increases the federal budget deficit by $4.6 billion, affecting indexed tax brackets, military and civil service pensions, and Social Security cost-of-living adjustments. In addition, divorce settlements, millions of workers' union contracts, pension agreements, and many private contractual agreements are indexed to the CPI, meaning that errors in this estimate will have a very large effect on the economy and federal and family budgets. Similarly, defense procurements are often indexed to the Producer Price Index, which is becoming less accurate as time passes.

The Gerontological Society of America has looked closely at the effects of budget cuts on the collection of aging-related data by the federal government over the past several years. In December of 1984, the Society published a paper, prepared by James Storey of Chambers Associates, that described the effect of budget reductions of the early 1980s on the collection of data on the elderly. A summary of this paper is submitted for the record.

An update of this report, also submitted for the record, was published early this year. In this update, Mr. Storey found that, although 1985 was not a good year for data collection, it was not as bad as the preceeding four years. However, the study shows that the Gramm-Rudman-Hollings balanced budget act threatens to renew the downward slide of data collection and analysis efforts.

The projected GRH formula that could mandate cuts of as much as 20 percent in non-defense discretionary spending compared to the pre-GRH 1987 projections would deal data collection efforts a severe blow, probably resulting in cancellations and delays in new activities, further cuts in survey sample sizes, stretchouts in survey frequency, fewer professional staff designing and analyzing the data collection efforts, and less extramural research. The capability of public and private organizations to monitor the health and welfare of the aged would be seriously impaired. Future policies would be based on obsolete data.

Reduced data availability means that research on social and economic issues would be limited. Government program managers would know less about how well the aged are served. Public and private planning for health care and other age-related facilities would be hampered. Private businesses would know less about how the markets for their products and services will change.

CONSEQUENCES OF REDUCING THE NUMBER OF PEOPLE IN SURVEYS

One of the great achievements of gerontologists over the past several decades has been the documentation of the diversity of the older population. It would be completely unacceptable and, in fact, absurd, to suggest that programs suitable for newborns are also appropriate for 15-year olds. Why should the same not be true for 65 and 80-year olds? But how will the differences be identified if the data are not there? Ironically, having learned about the diversity of the older population, the latest round of budget cuts has made it more difficult than ever to discover and describe the differences existing within that diversity. In many instances, budget cuts have been implemented by reducing the number of people interviewed in national surveys. While the reduction means that fewer interviewers must be paid and fewer completed surveys analyzed, reduced sample sizes have serious consequences for how the data can be used. Too few people surveyed in a given age group means that the information must be reported for larger age groups of people, rather than broken down by smaller age groups. Combining age groups will mask the very different experiences of people as they move into and through the upper ages.

The problem of reduced sample size and a consequent inability to disaggregate the elderly population by age groups will recur in several surveys (see Storey reports). The new Survey of Income and Program Participation (SIPP) has been designed to make available information on the income, wealth, and utilization of benefits by the entire population. Between 1984, when the first SIPP survey was conducted, and 1986, when the most recent wave of data was collected, the number of people interviewed aged 65 and over was reduced by more than 40 percent, from 8,333 to 4,890. Consequently, while the 1984 data on the elderly population will be analyzed separately for 65- to 74-year olds and those aged 75 and over, in the analysis of the 1986 data these groups will have to be analyzed together. There are just too few people in the 1986 sample to provide meaningful age detail. Yet, from other sources we know that those who have already reached the age of 75 are more likely to have lower incomes, have fewer assets (less wealth), and need more services.

Another consequence of the 1986 budget cut was to reduce the number of elderly people interviewed for the National Health Interview Survey (HIS) from 13,000 to 6,500. Because of this decrease, there are now too few cases in the HIS sample to describe accurately the health of people aged 85 and over. There will only be 500 from this age group in the sample. Those concerned with the costs of Medicare must know the health status and changes in the health status of this group, since its members are the heaviest users of the Medicare program. Also, the HIS sample is now too small to compare the health of rural elderly and urban elderly, a contrast important when identifying service needs. And, there are too few cases to describe the health of people in the few years before and after the current retirement age of 65 (that is, those between about 62 and 68). This is important because Congress has mandated a study of the health status of this age group to help examine the health implications of 1983 legislation that raised the retirement age to 67 by the year 2027. There are virtually no data to use to implement this Congressional mandate.

People over the age of 75 have never been included in the National Health and Nutrition Examination Survey, which had been administered on a 5-year cycle during the 1970s but will be administered on a 10-year cycle in the future. New research has shown that improved nutrition may be important in preventing and delaying the progress of such nutrition-related and potentially life-threatening diseases as osteoporosis. But with older people omitted from the only national survey that studies nutritional habits, policy makers will not be able to learn which population is most at risk, and whether, on a large scale, improving nutrition during the advanced years will actually improve health and perhaps decrease the cost of health care.

Census data was used in a major study of state-to-state migration patterns of older Americans during the period 1960 to 1980.[1] Using Census samples (the more detailed survey asked of 1 percent and 2.5 percent of the population), Dr. Charles Longino of the University of Miami discovered that, while older people make about half the interstate moves that younger people do, the rate at which they make interstate moves has increased over the past two decades. Since movers tend to be the more affluent, especially in the younger-old ages (65 to 74), these finding have implications both for states that are losing population and for states that are gaining residents. These data might be in jeopardy if the Census samples are reduced so that data cannot be obtained for individual states or for different age groups. Retirees have large impacts on the economies of the areas into which they move and where they spend their Social Security and pension incomes. They remove equal amounts of resources from the areas they have left. As they age, some will become net consumers of resources from areas, if and when they begin to receive publicly-funded services. These trends must all be properly tracked, so that the states and localities can be prepared.

CONSEQUENCES OF INCREASING THE TIME BETWEEN SURVEYS

Instead of administering the National Nursing Homes Survey (NNHS) every four years, it will now be fielded only once every eight years. The nursing home industry is undergoing rapid change, and this stretchout of survey timing means that there is no information on which to assess the impact of policy changes on the nursing homes and on which to base adjustments in rules and regulations in the interim years. The prospective payment system for reimbursing hospitals based on Diagnostic Related Groups (DRGs), first implemented in 1982, cannot be assessed until 1987, at which point it will have been in effect for five years. Although hospital stays have decreased as a result of PPS, there will be little data until after then on whether shorter hospital stays have resulted in patients being discharged to nursing homes; on lower and possibly inadequate levels of care upon premature discharge from a hospital; on deaths at home; or on whether the patients recovered from the condition that first brought them to the hospital. Lengths of stay mandated by DRGs cannot be adjusted if the consequences for the discharged patients are not known. Under current plans, the data will be available only at eight-year intervals.

In addition, policies that are meant to provide an alternative to institutionalization, such as those tested with Medicaid waivers to provide home health services, now can be evaluated only with infrequently collected data. Except in the case of some privately-initiated evaluations of particular programs in limited geographic areas, there is simply no information on how these policies have worked. This means that the changing role of Medicaid, the primary payer for half of all nursing home patients, cannot be judged until 1987. Although we do know the dollar amounts spent on Medicaid, there is no way to tell how many people these dollars are serving and whether the number has increased or decreased as a result of increasing funding for home health care services. Only anecdotal evidence exists, and that is hardly the basis for sound public policy.

CONSEQUENCES OF REDUCED PROFESSIONAL STAFFING

Because graduate schools cannot train students to run the big statistical surveys that the federal government manages, most governmental statistical organizations hire people with only about one or two years of experience. These people, typically hired in their 20s, spend about ten to fifteen years in on-the-job training, learning to design, implement, and manage the data sets so crucial to our national well-being.

However, over the past decade, so few people have been hired because of personnel ceilings and threatened or actual reductions in force that a whole generation of statisticians is missing from many statistical agencies. Both because of personnel ceilings that do not permit hiring young professionals and because working for the federal government has had such negative press coverage, many of the most talented young graduates cannot even consider working for federal agencies.

This means that, although the agencies may be limping along conducting their surveys and publishing analyses, when the current senior generation of statisticians retires, there could be virtually nobody to replace them. And given the way that training occurs, it will not be possible to hire people at that time who will be capable of doing the job. They will not have spent the ten to fifteen years required to mature and develop. The quality of the surveys will be threatened by untrained or incompetent management. That is a disturbing prospect as we head into the twenty-first century and the retirement of the baby boom generation.

RECOMMENDATIONS

In view of the important role that data will play in helping to meet the challenges of an aging society and at the same time realizing the tight fiscal constraints on the federal budget, the GSA recommends several steps to ensure better coordination among federal statistical programs to make existing programs more efficient. On the issue of coordination, previous witnesses testified on a recommendation to establish Statistical Centers on Aging. The Gerontological Society of America endorses this recommendation and further suggests that such Centers, if established, have an advisory board constituted of representatives of the community of researchers, policy analysts, and policy makers, the primary users of such data. These users can help identify critical information needs and can help ensure that the data produced will be in the most useful form.

These proposed Centers would go a long way toward helping reduce program redundancies and identifying vital data gaps. The Gerontological Society of America believes that if successful, the Centers can provide a model for coordinating data on other sub-population groups such as children.

An example of the value of advice from users is demonstrated by the work of The Gerontological Society of America on the 1990 Census. The decennial Census is one of the most important sources of information on the lives of our citizens. In early 1985, the Society submitted a set of recommendations to the Census Bureau that would improve the ability of those interested in the aging population to use data obtained by the Census. These recommendations are submitted for the record.

The recommendations included making the definition of disability more applicable to older people; measuring the existence of family networks and the geographic distance between older people and their families, so that local area planners could determine whether informal support systems exist; adding a question on pension income; adding a question about non-money income such as food stamps, housing assistance, and employer-provided fringe benefits; identifying board and care homes; clarifying the questions on race and hispanic origins; and collecting data from residents of institutions.

The Bureau of the Census was receptive to the GSA suggestions. Of the seven recommendations involving revision of the Census questionnaire, six are included in current field testing. These are the questions on disability, pension income, in-kind benefits, board and care homes, defining race and hispanic origin, and adding the institutional population to the data base. In addition, of the GSA's three recommendations for improving Census products, two have been adopted tentatively (publishing data in a more disaggregated form up to 85 and over, and providing tabulations that would permit analysis of retirement status with respect to such variables as income, source of income, and geographic location). The third (providing 100 percent data by block for the entire nation, as well as low-cost tabulations for subgroups) is still under discussion.

The GSA committee that generated these recommendations was composed of both producers and users of these data who came together to share their concerns and suggestions. The result was a wide-ranging series of recommendations, based on experience with the strengths and weaknesses of the Census data, that, because they were well thought-out and realistic, may well be incorporated into the 1990 Census or even beyond. This experience of involving both producers and users of federal statistics in the debate on their collection and analysis is very important and provides a useful model for creating advisory boards for the Statistical Centers for Data on Aging.

Personnel Recommendations

The Gerontological Society of America recommends that the personnel needs of the federal statistical agencies, particularly those that handle data on the aging, be examined carefully, and suggests two specific actions. First, the personnel ceilings at those agencies should be adjusted to a level that permits hiring new professional staff to help ensure an adequate supply of trained managers to run the data base programs in the future and protect the long-run integrity of the data bases. The Gerontological Society of America also suggests that the federal statistical agencies be allowed to take steps to attract talented young statisticians willing to make a career in these agencies, including some protection against the risks of across-the-board reductions in work force in the most crucial areas. These career workers are the key to a sound federal statistical system, which in turn is critical to the development of appropriate programs and policies.

Budgetary Recommendations

The report prepared by Mr. Storey reveals some consequences of recent budgetary actions and provides a baseline for assessing future directions for data collection agencies. Certainly, no further budget cuts should be made. Given the importance of accurate information in every sphere of governmental policy, past budget cuts have brought data collection efforts to their bare minimum and have seriously impaired the utility of many existing data bases. Further cuts could imperil our ability to monitor and track the conditions of the aged and our ability to determine changes in their condition.

While some budgetary fat has been trimmed, some reductions have diminished the usefulness of the data being collected, as the above discussion described. These cuts should be restored so that, for example, researchers and policy makers will have access to detailed age breakdowns which help differentiate policies for the very different needs and resources of the different age groups that constitute the elderly population.

Preservation of adequate data collection efforts beyond 1986 depends on Congress imposing its own spending priorities in place of the across-the-board budget cuts of discretionary spending which could be required by the GRH process. Congress is committed to a major reduction in the budget deficit, with or without an alternative to GRH, and the Society realizes that budgets for statistical agencies will remain very tight in the near future.

However, a close look should be taken at the ways in which past and future reductions in data collection efforts have affected and will continue to affect the ability to make sound public policy, and whether these reductions in the long or short run will actually result in increased costs. The significant reductions in policy research and analysis capabilities have already had a major impact on the knowledge base previously available to lawmakers and policy makers. Continuing such reductions will have serious, tangible effects on the income, health, and well-being of all Americans, young and old. While the old are typically more directly dependent on federal programs, a recent Society study has documented the interdependence between the welfare of the young today and the aged of both today and tomorrow.[2] We do not wish to say that no budget should ever be cut and believe that some cuts can be absorbed with relatively little ultimate effect. However, we strongly urge that the foundation on which a comprehensive edifice of laws, policies, and regulations is built not be eroded by short-sighted, simplistic, politically expedient budget cuts that will cost the government far more than they will save.

FOOTNOTES

1 Charles F. Longino, Jr., "State to State Migration Patterns of Older Americans for Two Decades." Center for Social Research in Aging, University of Miami, Coral Gables, FL, March, 1986.

2 Eric R. Kingson, Barbara A. Hirshorn, Linda K. Harootyan, "The Common Stake: The Interdependence of Generations (A Policy Framework for an Aging Society)." The Gerontological Society of America, Washington, DC, April, 1986.

EXHIBITS SUBMITTED BY JACOB BRODY, M.D.

FIGURE 1

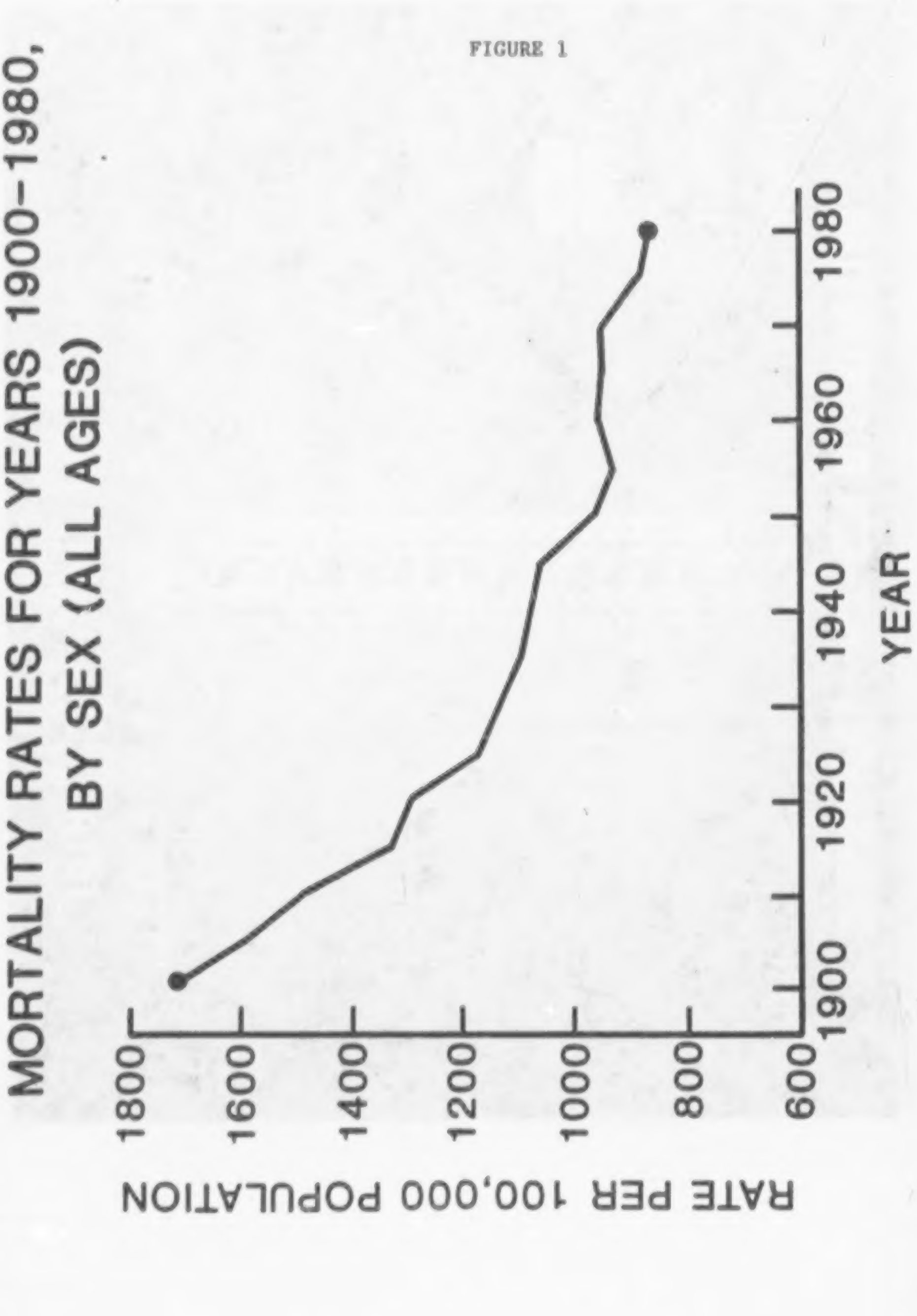


FIGURE 2C

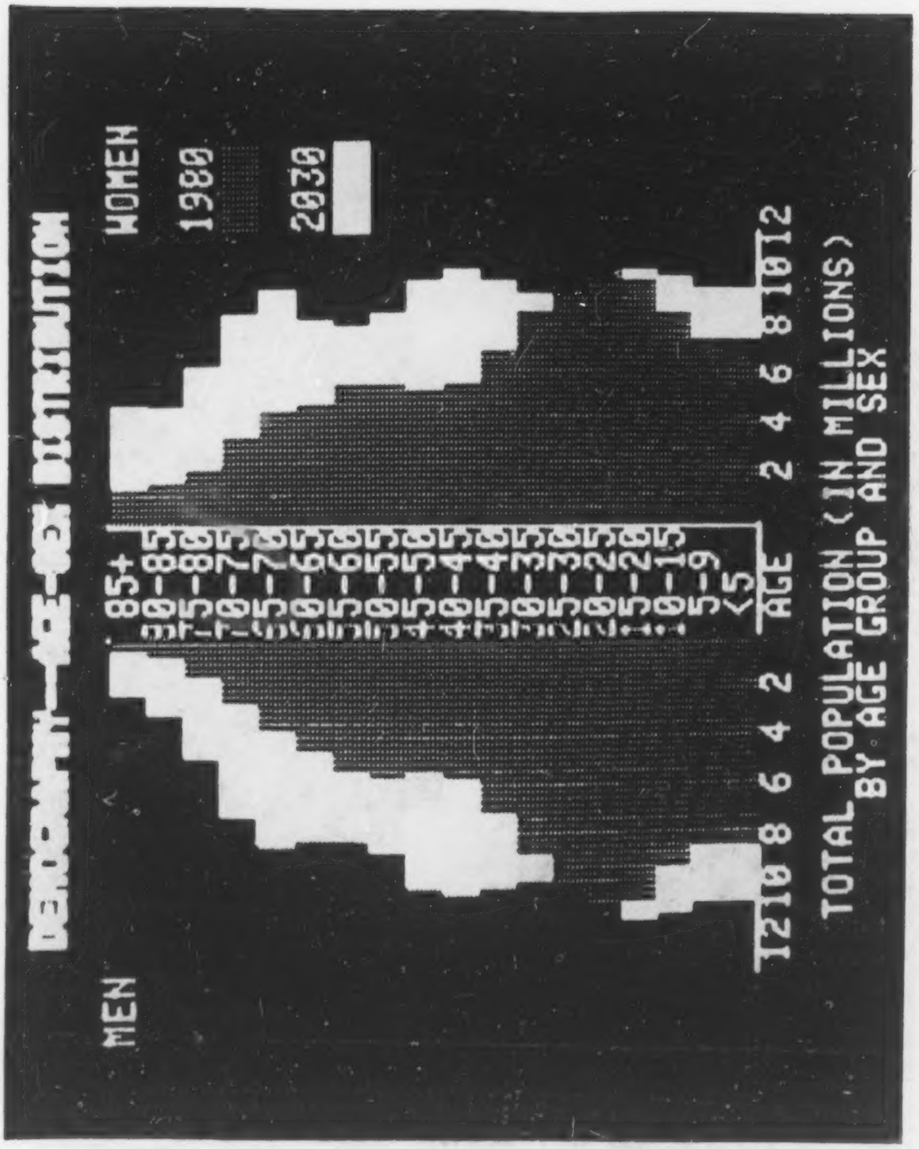
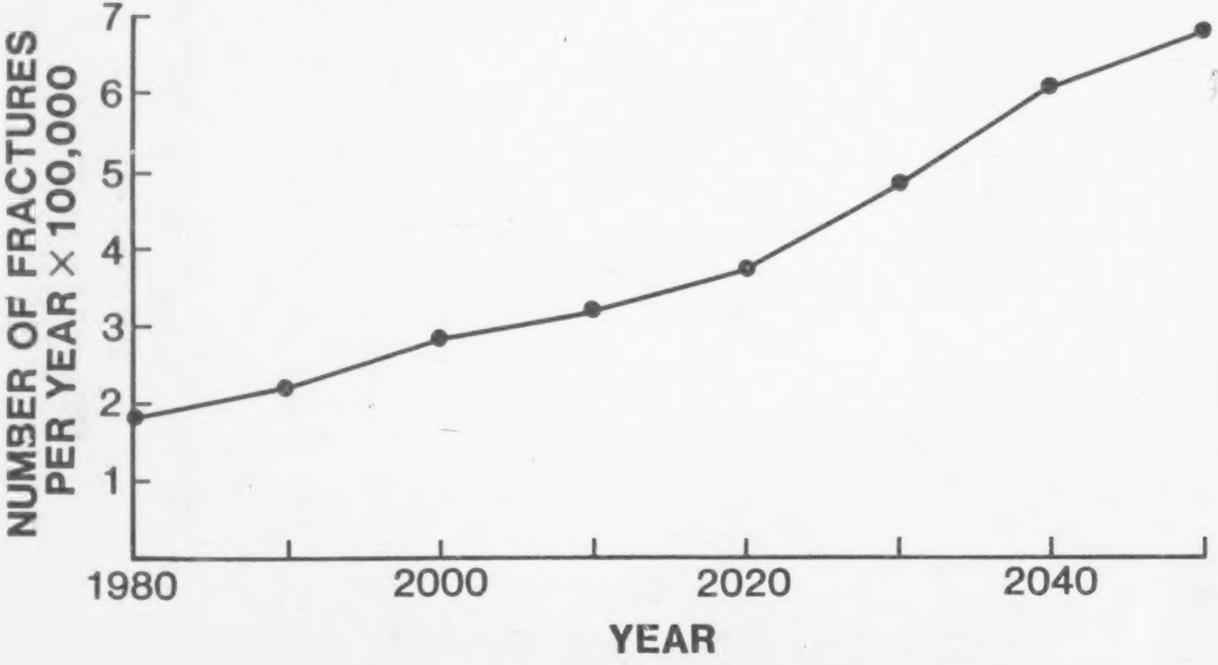

DEMOGRAPHY — AGE-SEX DISTRIBUTION
MEN
WOMEN
1980
2030
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
<5
AGE
12 10 8 6 4 2
2 4 6 8 10 12
TOTAL POPULATION (IN MILLIONS)
BY AGE GROUP AND SEX

FIGURE 3A

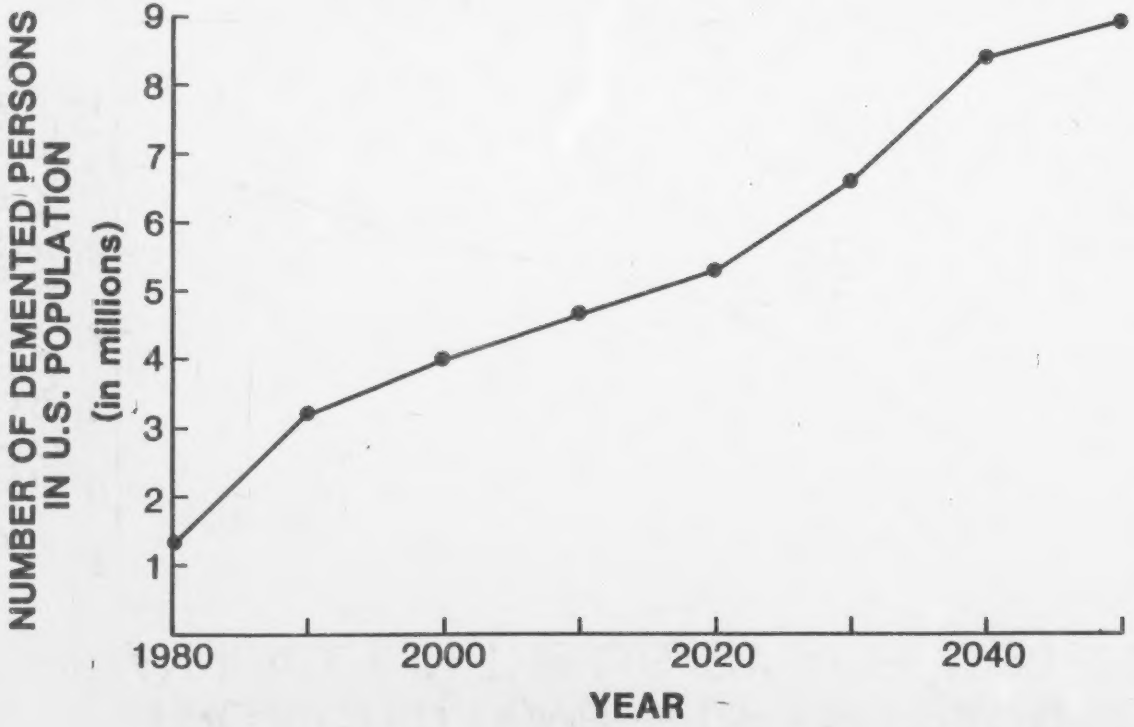
PROJECTED NUMBER OF HIP FRACTURES ANNUALLY IN THE U.S. BY AGE: 1980–2050



"Source: NCHS and U.S. Bureau of Census projections"

FIGURE 3B

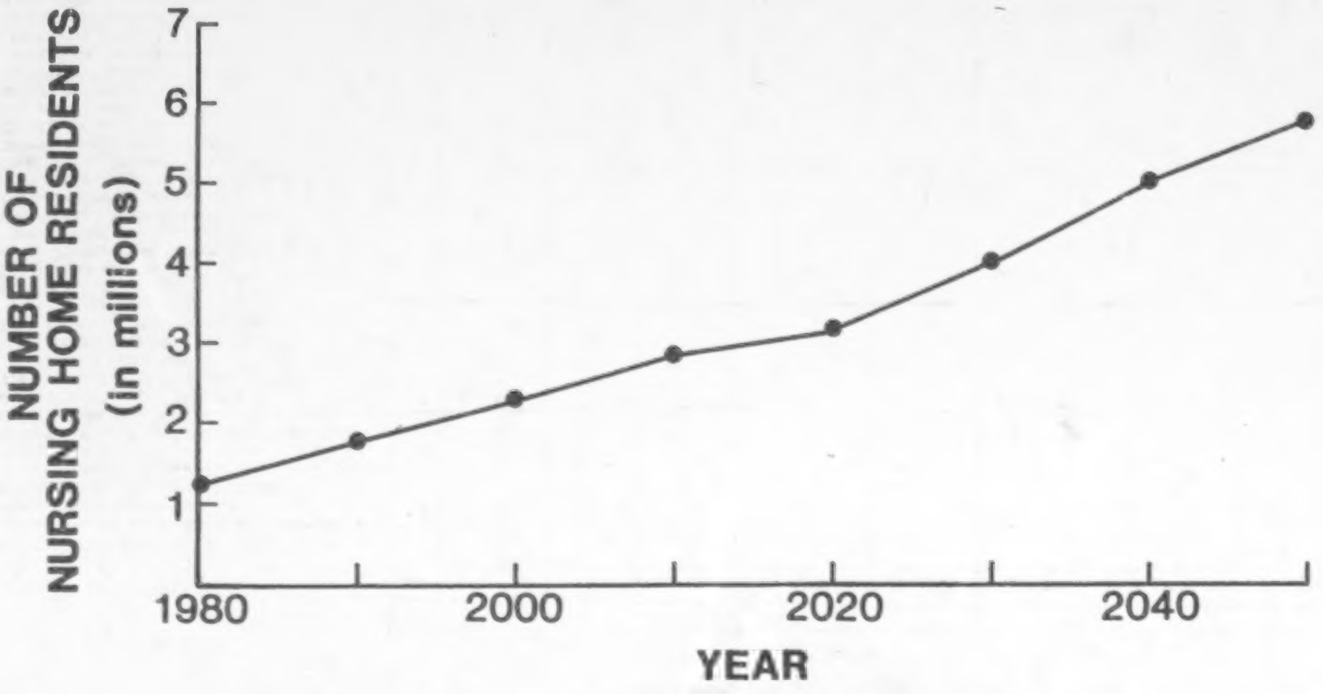
PROJECTED NUMBER OF DEMENTED PERSONS
IN THE U.S. BY AGE: 1980–2050



"Source: NIA prevalence estimates and U.S. Bureau of Census projections"

FIGURE 3C

PROJECTED NUMBER OF NURSING HOME RESIDENTS IN THE U.S. BY AGE: 1980–2050



"Source: NCHS and U.S. Bureau of Census projections"

Compiled by Bureau of the Census
May 2, 1986

SUMMIT MEETING ON AGING-RELATED STATISTICS

SUMMARY OF ISSUES

ISSUES	AGENCY																			
	AOA	Census	BLS	IRS	NCI	NCHS	NCHSR	NCNR	NEI	NHLBI	NIAAA	NIAMS	NIA	NICHD	NIDDK	NIDR	NIMH	SSA	VA	HCFA
1. PROCESS TO GET NEEDED DATA																				
a. Bridge health and socio-econ. data	X	X		X	X		X	X		X			X	X	X	X		X		
b. Disaggregate beyond 65+	X	X	X		X					X			X			X		X		
c. Longitudinal data; transitional probabilities		X		X		X					X	X	X		X			X	X	
d. Improve data quality	X	X		X		X				X			X							
e. Linkage of data systems, confidentiality		X		X		X				X			X	X						
f. Cohort studies						X				X			X	X				X		
g. Sample size (e.g., oldest old)	X	X			X							X	X	X						
h. Timely release of data		X											X							
i. Interagency cooperation		X				X							X				X			
j. Standardize definitions, concepts													X					X		
k. More analysis by data producers													X							
2. DATA NEEDED																				
a. Institutional pop.		X		X		X	X		X				X			X			X	
b. Labor force, unempl., occup. mix			X				X		X				X					X		
c. Race, gender					X		X			X		X	X							
d. Retirement, pension income			X															X		
e. Income sources, assets	X						X											X		
f. Resource allocation between generations														X						
g. Consumption patterns			X																	
h. International data (social, health, econ.)		X			X								X					X		
i. Mortality, forecasting					X	X				X			X	X				X		
j. Causes of death					X	X				X	X		X						X	
k. Active life expectancy						X		X					X					X		
l. Morbidity, disability: improve measures of incidence, prevalence, risk factors, severity, fatality, classification	X				X	X	X	X	X	X	X	X	X		X	X	X	X	X	
m. Concomitant medical problems					X	X							X							
n. Health costs by disease	X				X		X		X					X		X				X
o. Preventive measures	X					X		X			X				X					
p. Service cost and utilization	X				X		X		X	X	X			X		X	X		X	X
q. Type, no., & distrib. of care providers	X				X		X									X				
r. Mental retardation							X							X						
s. Health insurance coverage							X													

Note: This is an arbitrary categorization of issues based on statements of agencies prepared for the Summit Meeting on Aging-Related Statistics, May 2, 1986.

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STATEMENTS OF FEDERAL AGENCIES
FOR
SUMMIT MEETING ON AGING-RELATED STATISTICS

May 2, 1986

Stone House, NIH Campus

Jointly sponsored by:

T. Franklin Williams, M.D.	Dr. John G. Keane
Director	Director
National Institute on Aging	Bureau of the Census

Vital Issues
As Identified By
The Administration on Aging

The Administration on Aging (AoA) is the principal Federal agency designated by Congress to carry out the provisions of the Older Americans Act of 1965. The Act seeks to remove barriers to economic and personal independence for older people and assure the availability of appropriate community and family based services for those older people in the greatest social or economic need.

AoA aids States and communities in developing comprehensive and coordinated service systems to serve older individuals. AoA's programs reach into most areas of the United States through a network of public and private agencies which includes 57 State and Territorial Units on Aging and, at the community level, approximately 660 Area Agencies on Aging and 25,000 service providers.

Unlike most of the agencies represented at the "Summit Meeting," AoA is not primarily a research or data collection organization. Because of the broad mandate of the Older Americans Act, AoA utilizes data from many Federal sources on a wide variety of topics.

The Vulnerable Elderly

AoA's primary goal is to ensure that the "vulnerable" elderly--those at risk of institutionalization or unable to function unaided in the community--have services available which will enable them to remain in the community as long as possible and pursue a meaningful, rewarding, and dignified lifestyle. AoA has encouraged the Census Bureau to include a question on functional disability in the questionnaire for the 1990 census. AoA recognizes the problems involved in capturing significant and accurate health information in a limited space on a self-administered questionnaire. However, health-related information about the older population at the local level is the most critical need for local service planners.

In addition to local data, more information is needed on:

- The size and characteristics of this population;

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- The amount and type of service provision which will allow them to remain in the community; and
- The costs of such services.

Efforts to gather information on the older population by age group rather than in the aggregate should be pursued vigorously. In this regard, NIA is to be congratulated on its current research initiative on the "old-old." Given the considerable difference in characteristics between the "young-old" and "old-old," and the disproportionate share of health and supportive service resources expended on the very old, more efforts should be made to increase sample size in the oldest age groups in our national surveys and to develop other methods of gathering reliable information.

Caregivers

Current research indicates that the primary source of caregiving for the vulnerable elderly is not formal service agencies in the community, but the informal support system of family members and friends. About 80% of care provided to the vulnerable elderly in the community is provided by informal caregivers. More information is needed on:

- The extent and relationship of this informal network;
- The amount and type of care provided; and
- The barriers to a wider provision of such care.

Given the projected increase in the number of older people, particularly the oldest of the old, there is likely to be considerable strain on the informal caregiving network in the future. More information is needed on the nature of volunteer caregiving, the strengths and weaknesses of such care, and the prospects for increasing voluntarism among the elderly.

Preparation For The Future

There are two levels of "planning for the future" that AoA believes are important and will continue to stress in its education and dissemination efforts--planning at the individual level, and planning at the societal level.

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Important aspects of individual planning are health education and promotion aimed at preventing premature death or disability and individual and financial planning. The potential benefits to the individual of activities are quite clear, and research efforts in these areas should certainly continue.

At the societal level, more information is needed on the overall nature of future aging society and the extent to which the increase in the numbers of dependent older people will be at least partially counterbalanced by the projected decrease in the number of children.

Preparation for the future requires information about future needs of the older population. AoA is more than willing to work with the other agencies represented at this "Summit Meeting" to disseminate the results of their research in these areas.

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4/17/86

UNITED STATES DEPARTMENT OF
COMMERCE
NEWS
WASHINGTON, D.C. 20230

BUREAU OF
THE
CENSUS

VITAL POLICY ISSUES REGARDING AGING-RELATED STATISTICS

DR. JOHN G. KEANE
DIRECTOR, BUREAU OF THE CENSUS
WASHINGTON, D.C.

SUMMIT MEETING ON AGING-RELATED STATISTICS
NATIONAL INSTITUTES OF HEALTH (STONE HOUSE) - BETHESDA, MARYLAND

MAY 2, 1986

INTRODUCTION

CENSUS BUREAU PERSPECTIVES AT THIS FIRST-OF-ITS-KIND MEETING FOCUS ON THREE AREAS:

1. THE CLARION FOR COOPERATION,
2. BRIDGING HEALTH AND SOCIO-ECONOMIC VARIABLES, AND
3. OUR EMERGING CHALLENGES.

IN THAT ORDER, I SHALL OVERVIEW EACH OF THESE SUB-TOPICS.

1. THE CLARION FOR COOPERATION

THE SINGLE MOST VITAL ISSUE IN THE DEVELOPMENT OF AGING-RELATED STATISTICS IS TO ESTABLISH COOPERATIVE ACTIONS AMONG FEDERAL AGENCIES THAT WILL EXTEND OUR CAPABILITIES TO MEET OUR GOALS IN A COST-EFFICIENT WAY. THROUGH COOPERATION, WE CAN IMPROVE OUR ABILITY TO LINK DATA COLLECTION AND RESEARCH TO PLANNING AND POLICY DEVELOPMENT. WE CAN PROVIDE BETTER INFORMATION FOR SETTING PRIORITIES FOR DATA COLLECTION AND RESEARCH THAT MEET THE TESTS OF SCIENTIFIC VALUE, SOCIAL RELEVANCE, AFFORDABILITY, AND POLITICAL VIABILITY.

BY WORKING TOGETHER, WE WILL BE BETTER ABLE TO ISOLATE VITAL POLICY-RELATED AREAS NEEDING DATA AND TO FILL THOSE DATA GAPS. WE CAN EXTEND THE USE OF LIMITED RESOURCES, REDUCE WASTE AND OVERLAPPING AREAS OF INDIVIDUAL AGENCY ACTIVITY, AND WORK TOWARDS A UNIFORM, COMPLEMENTARY APPROACH ACROSS FEDERAL AGENCIES WHERE APPROPRIATE. WE CAN ALSO IMPROVE ACCESS AND DISSEMINATION OF DATA FOR PLANNING, PROGRAM MANAGEMENT, UNDERSTANDING OF TARGET POPULATIONS, AND DEVELOPMENT OF POLICY OPTIONS. BY RECOGNIZING OUR MUTUAL INTERESTS, WE CAN ENCOURAGE COLLABORATIVE RESEARCH AS WELL AS INFORMATION-TECHNOLOGY SHARING AMONG AGENCIES.

2. BRIDGING HEALTH AND SOCIO-ECONOMIC VARIABLES

WE EXPECT THAT ONE IMPORTANT OUTCOME OF COOPERATIVE ACTION IS THAT WE CAN BEGIN TO BUILD A BRIDGE BETWEEN HEALTH AND SOCIO-ECONOMIC DATA, AND EVENTUALLY, BETWEEN POLICIES IN THOSE AREAS. FOR EXAMPLE, THE USE OF HEALTH AND LONG-TERM CARE SERVICES IS AFFECTED BY HEALTH, SOCIAL, AND ECONOMIC FACTORS. PUBLIC POLICY FOR LONG-TERM CARE HAS TO BE BASED ON ALL THE RELEVANT RISK FACTORS SUCH AS RETIREMENT TRENDS; HOUSING COSTS AND CHARACTERISTICS; TAXATION POLICY; THE CHARACTERISTICS OF THE FAMILY AVAILABLE FOR INFORMAL SUPPORT; SOCIAL TRENDS SUCH AS LIVING ARRANGEMENTS AND THE AGE AT WHICH WOMEN MARRY, HAVE CHILDREN, WORK IN OCCUPATIONS COVERED BY SOCIAL SECURITY AND RETIREMENT PLANS, DIVORCE, AND BECOME WIDOWED; THE USE OF ADVANCED MEDICAL TECHNOLOGY; THE ECONOMIC STATUS OF THE INDIVIDUAL AND THE ECONOMICS OF PAYING FOR CARE, AND SO ON.

THERE ARE OTHER UNANSWERED QUESTIONS ABOUT THE RELATIONSHIP BETWEEN HEALTH AND SOCIO-ECONOMIC VARIABLES, INCLUDING: WHAT ARE THE SOCIAL AND ECONOMIC CORRELATES OF MORBIDITY AND THE DECLINE IN MORTALITY? WHAT ARE THE INTERRELATIONSHIPS OF SOCIAL SUPPORT, ECONOMIC STATUS, AND HEALTH STATUS? HOW WILL THE INCREASED LABOR FORCE PARTICIPATION OF WOMEN AND REDUCED FAMILY SIZE IMPACT ON CARE OF OUR ELDERS? HOW DO CHANGES IN THE NATURE AND DURATION OF ILLNESS AMONG THE ELDERLY AFFECT THE ECONOMIC STATUS OF THE FAMILY? WHAT

IS THE EFFECT OF UNEMPLOYMENT ON HEALTH? HOW DO THE HEALTH NEEDS OF THE ELDERLY RESPOND TO THE AMOUNT AND TYPE OF RESOURCES ALLOCATED TO DISEASE PREVENTION AND TREATMENT?

3. OUR EMERGING CHALLENGES

IN THE COMING YEARS, THE CENSUS BUREAU WILL FACE SOME IMPORTANT STATISTICAL ISSUES CONCERNING AGING-RELATED STATISTICS. THESE WILL REQUIRE COORDINATION FOR SUPPORT OF THE ACTIVITIES. FUNDING FOR RESEARCH SHOULD ALLOW FOR DATA DEVELOPMENT. AMONG THE MOST IMPORTANT ISSUES ARE:

(1) THE LINKAGE OF ADMINISTRATIVE RECORDS WITH SURVEYS WHILE PROTECTING CONFIDENTIALITY;

(2) THE TIMELY RELEASE OF DATA;

(3) DEVELOPMENT OF LONGITUDINAL SURVEYS AND THE STATISTICAL METHODOLOGY FOR ANALYZING SUCH FILES;

(4) IMPROVING THE QUALITY OF THE DATA, PARTICULARLY IN INSTITUTIONS WHERE PERSONS MAY BE COGNITIVELY IMPAIRED, AND

(5) ENLARGING SAMPLE SIZES FOR THE ELDERLY POPULATION SO THAT TABULATED DATA ARE RELIABLE FOR AGE GROUPS BEYOND THE COMMONLY USED TERMINAL CATEGORY OF "65 YEARS AND OVER."

IN LESS THAN 25 YEARS, A LARGE AGING SOCIETY WILL BE UPON US WHETHER OR NOT WE HAVE SUFFICIENT INFORMATION FOR POLICY. IT IS INCUMBENT UPON US TO COOPERATE TO PROVIDE THE NEEDED INFORMATION FOR THAT AGING SOCIETY.

U.S. Department of Labor

Commissioner for
Bureau of Labor Statistics
Washington, D.C. 20212

Centennial
of Labor
Statistics

APR 18 1986

T. Franklin Williams, M.D.
Director
National Institute on Aging
Public Health Service
Department of Health
and Human Services
Bethesda, Maryland 20205

Dr. John G. Keane
Director
Bureau of the Census
Department of Commerce
Washington, D.C. 20233

Dear Dr. Williams and Dr. Keane:

I am responding to your letter of March 24. As you know, I will be unable to attend the May 2 Summit Meeting on Aging-Related Statistics and thus am sending Mr. Philip Rones as an observer. Mr. Rones has studied the subject of aging and older workers, and has written numerous articles on the subject.

The Bureau of Labor Statistics primary interest in regard to older persons is in their labor market performance and consumption patterns.

It is often hard to interpret data on unemployment, discouragement, and labor force participation for older workers. The unemployment rate--which, by definition, is the number of active jobseekers divided by the labor force--is lower for older workers than for any other age group. But these low jobless rates may reflect the older workers' tendency to end a period of job search by leaving the labor force, an option not feasible for most younger workers. Also, labor force participation, often used as a measure of retirement trends, treats retirement as sudden and absolute, whereas we know it to be, for many, a gradual transition.

In terms of consumption patterns, the elderly need to be examined as two groups, 65-74 and 75 years and over because the characteristics, incomes, and spending patterns are quite different. For the older group, the share of total expenditures going for housing costs and health care is considerably higher than for the 65-74 group. This is in spite of the fact that over 90 percent of homeowners in the older group live in mortgage free homes.

T. Franklin Williams, M.D.--2--
Dr. John C. Keane

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Policies regarding older workers have often been at odds. While pressures on the Social Security System have necessitated changes that will increase incentives to work additional years, some employers appear to be expanding the use of early-out arrangements to help reduce labor costs. Indeed employer financing of pension costs is becoming an extremely important element of overall compensation cost. Perhaps changing labor market demographics will bring many of these conflicting interests into line.

I am indeed sorry not to be able to participate in your meeting. The issues are important ones, and I am sure the meeting will be successful.

Sincerely yours,

JANET L. NORWOOD
Commissioner

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
WASHINGTON, D.C. 20201

THE ADMINISTRATOR

APR 30 1986

T. Franklin Williams, M.D.
Director
National Institute on Aging
National Institutes of Health
Building 31, Room 2C02
Bethesda, Maryland 20205

Dear Dr. Williams:

I want to thank you for the opportunity to attend the Summit Meeting on Aging-Related Statistics. While I cannot attend, I would like to take the opportunity to include HCFA's principal concerns on aging-related statistics in the record of the meeting. Our "vital few" issues coincide with those identified by the Secretary as priority areas for the Department; namely, Medicare acute and long-term care catastrophic protection, and "how to be equally fair to beneficiaries, providers, taxpayers . . . and keep quality of care in mind as we try to reduce costs." A brief statement of these issues follows.

Medicare Acute Catastrophic Protection

The impact of cost sharing measures, such as health care deductibles, coinsurance, charges by physicians that exceed allowed charges and health care services beyond the scope of the Medicare benefit package, on aged persons needs to be reexamined and accurately described.

Long-term Catastrophic Protection

Funding of long term care for the aged population will become increasingly important as the aged population "ages." An increasing proportion of the aged population will require institutional care in nursing homes or continuing home support for functional and health maintenance. Future sources of funding for such care are problematic. Equitable systems to encourage and promote "internal support" systems as alternatives to institutional care must be pursued.

Quality and Cost Balance

Proper balancing of quality of health care with efficiency in provision of health care services for the aged will become increasingly important. Efforts to judiciously reduce unnecessary services in order to accommodate governmental and private needs to control health care expenditures must be made within an environment that continues to guarantee levels of quality care equivalent to that provided to other population sectors.

Page 2 — T. Franklin Williams, M.D.

I look forward to attending future meetings and am most interested in receiving the statements that have been prepared by the participating agencies. I have asked Michael McMullan, Director of our Office of Statistics and Data Management, Bureau of Data Management and Strategy, to represent HCFA as an observer. Thank you again for your invitation.

Sincerely yours,

Henry R. Desmarais

Henry R. Desmarais, M.D.
Acting Administrator

Excerpt from:

Fritz Scheuren
"Methodologic Issues in
Linkage of Multiple Data
Bases"

Internal Revenue Service

Potential Data Systems Deserving Further Study

Within the framework just given, there seems to be a clear need to intensively examine the potential of particular data linkage systems to answer certain questions. We will illustrate this point by looking at one of the most pressing areas in the United States where better data are needed -- this is on our rapidly growing aged population. Even if we confine ourselves to this single area, many subsidiary issues must be addressed. For example, where are the greatest gaps: in data on health, general demographic information, financial data, or the extent to which federal programs provide support? In what follows, there has been no attempt to answer this question. To do so, we would go well beyond the scope of the present paper. Instead, there is a discussion of four data linkage environments that, depending on the answer to the question, may warrant further study. Special emphasis has been placed on the limitations of working in each of these settings and of the role that a strong outside user might play in overcoming those limitations.

Social Security and Health Care Financing Administrations -- The Social Security (SSA) and Health Care Financing Administrations (HCFA) are unlikely to take the lead in building and maintaining *general purpose* statistical data linkage systems, in part because of a reduced emphasis on basic and applied research. Nevertheless, the program-oriented statistical activities of these agencies will continue to give them an important role in data linkage efforts which are consistent with agency missions. The potential at SSA and HCFA for providing improved sources of statistics on the aging population depends on the extent to which they are able to: (1) maintain major in-house data linkage efforts, like the Continuous Work History Sample (e.g., Buckler and Smith, 1980) and the Medicare Statistical System (U.S. Health Care Financing Administration, 1983); (2) continue to sponsor or co-sponsor periodic or *ad hoc* surveys; and (3) cooperate in linkage studies sponsored elsewhere (for example, in the Survey of Income and Program Participation or in the Health Interview Survey) if they are in support of the agencies' missions.

However, these efforts would need to be coupled with strong outside user support. At SSA and HCFA, there may be a particularly pressing need for outside users to aid in the resumption of some form of public release of subsets, at least, of the administrative samples now being employed almost solely for in-house purposes.

Internal Revenue Service -- It seems pointless to speculate upon the degree to which interagency data linkages can or should take place involving Internal Revenue Service (IRS) data. Formidable statutory barriers narrowly limit access to tax records and, even when the legal requirements can be met, many other agencies, notably the Census Bureau, feel they would be unable to engage in a cooperative study because of concerns about public perception. American social customs, particularly concerns about "Big Brother," stand as nearly insurmountable obstacles in the short run.

It is possible, though, to use IRS records essentially all by themselves as a basis for studying the aged population. This may seem surprising because the statistical program of the Internal Revenue Service is not looked at typically as a source of such information. Certainly the *Statistics of Income* publication series has focused very little on the aged, and then mainly through the use of the age exemption to identify taxpayers 65 years or older (e.g., Holik and Kozielec, 1984). Broader-based research has been possible through occasional linkages between the IRS's Individual Income Tax Model File and Social Security information. In a few cases, these linkages have resulted in public-use files (DelBene, 1979). What has not been done is to look at the aging population longitudinally, although this is fairly straightforward, at least back to 1972. Furthermore, with the recent addition of complete SSA year-of-birth information to IRS files, it will be possible to routinely study age cohorts by means other than the age exemption. It is also noteworthy of mention that linkages between IRS files and the recently instituted National Death Index have just been successfully instituted (Dentz, 1985).

Tax returns probably represent the single best source of financial information and could, therefore, prove of value in studying the aging process. There are, however, three main limitations to their use:

- First, the income data, while of exceedingly high quality (relative to surveys), are incomplete since certain nontaxable incomes have been omitted (e.g., tax-exempt bond interest and welfare payments). Until recently, social security benefits were unavailable but they are now potentially taxable (beginning with 1984).

- Second, the population coverage of income tax returns is incomplete. In fact, only about half the population ages 65 years or older show up as taxpayers on income tax returns. Again, recent changes have a bearing here since information documents, notably Forms 1099 from Social Security, are filed with the Internal Revenue Service for all social security beneficiaries. This change permits an expanded population concept that could be essentially complete for the aged population.

- Third, the tax return is exceedingly awkward as a unit of analysis for some purposes since it does not always conform to conventional family and household concepts (Irwin and Herriot, 1982). It is possible though, using information documents like Forms W-2 (for wages), Forms W-2P (for private pensions), and Forms 1099 (for social security payments, dividend, interest, etc.), to develop approximate financial profiles of virtually all individuals aged 65 or older. (Major gaps would exist, of course, for supplemental security income recipients and recipients of veterans disability benefits.) There does not appear to be much hope in inferring changes in lifestyles directly from the current IRS information, although the proposed addition of dependent social security numbers could lead to real progress (Alvey and Scheuren, 1982).

Depending on its extent, the cost of maintaining an IRS data linkage system to study aging could be quite modest. Public-use files are possible; but, as with the Social Security and Health Care Financing Administrations, strong outside support would be needed.

National Center for Health Statistics -- Recent changes (Sirken and Greenberg, 1983) at the National Center for Health Statistics suggest that the Center may be assuming a leading role in sponsoring data linkage systems. Naturally and appropriately, the focus of these systems will be quite narrow, looking almost solely at health concerns. The National Health Interview Survey (HIS), involving about 40,000 households annually, appears to be the Center's main survey vehicle for the approach it is planning to take. Continued periodic matching to Medicare records seems planned (Cox and Folsom, 1984) and, of course, the National Death Index can be expected to be fully exploited (Patterson and Bilgrad, 1985). Still other linkage efforts are underway (e.g., Johnston, et al., 1984) which, taken together, suggest that the Center is pursuing a coherent, fully integrated approach, both among its surveys and towards needed vital record systems.

When the social security number question was added to the HIS a few years ago, it was largely for matching to the National Death Index. Great care initially was given to securing informed consent from respondents before obtaining the information. This approach proved tedious and expensive. Now the social security number question is simply asked without much explanation; and, only if requested, are reasons given for why the information needs to be obtained (see Appendix C). Response rates are quite high, about 90%, and it appears that the HIS may constitute a major vehicle for a successful data linkage approach to studying aging. Concerns exist about the reidentification problem, but exactly how the Center will deal with this factor is unclear.

Bureau of the Census -- Historically, the Census Bureau has played a major role in federal data linkage systems involving surveys, sometimes as the sole sponsor (e.g., Childers and Hogan, 1984), but often as a partner in conducting a particular study (e.g., as with Social Security, Bixby, 1970). Much of this work has focussed on the Current Population Survey (Kilss and Scheuren, 1978). Of more promise in future studies of aging has been the development of the Survey of Income and Program Participation (SIPP), which has as one of its design elements the notion that data linkages would be attempted, at least to Social Security information (Kasprzyk, 1983). SIPP, which may settle down to a sample size of about 30,000 households annually, is certainly of sufficient size and scope to look at many general demographic, financial and program related questions concerning aging. The SSN reporting rate is on the order of 90%; hence, the needed resources to "perfect" the linkage (and the analysis problems resulting from faulty or incomplete linkage) should be entirely manageable. Oversampling is possible for particular subgroups (e.g., those aged 65 or older); however, unfortunately, SIPP, like the HIS, is confined to the noninstitutional population and for studies of the very old it may not be suitable alone.

Two difficulties exist with SIPP that further research may resolve. First is the extent to which informed consent is being obtained when the social security number is being secured (SIPP's approach is similar to that in the HIS--see Appendix D). Related to this concern, of course, is the extent to which such consent is felt to be needed. The second issue, and one that seems exceedingly troublesome to the Census Bureau, is the "reidentification" problem. (Briefly stated, the reidentification problem is particularly acute where linkage is concerned, because the cooperating agencies might have enough data on the linked file to reidentify virtually all of the individuals linked.)

The Census Bureau appears to be searching for a solution that involves either simply not releasing public-use files of linked data or releasing public-use files where only very limited linked data have been provided and some kind of masking technique has been employed to prevent reidentification. Given these restrictions, it must be said, there seem to be real difficulties in concluding that there are sufficient benefits to outside users of a SIPP-based data linkage system. Some further comments on this dilemma and ways a general research program could address it are given below.

General Issues Deserving Further Study

Further research is needed on a wide range of data linkage issues, both structural and technical. Four, in particular, stand out from the rest and deserve special attention: ethical and legal concerns, public perception questions, finding solutions to the reidentification problem, and finally, analysis issues in the presence of matching errors.

Ethical concerns such as those raised by Gastwirth (1986) seem to need a more specific answer than they have been given so far (e.g., as by Dalenius, 1983). What might be done is to obtain some data directly bearing on how respondents actually think about data linkage. We could approach this in a way similar to the earlier study by the Committee on National Statistics concerning confidentiality guarantees (Committee on National Statistics, 1979). Within the context of current survey efforts in HIS and SIPP it might be extremely valuable to know how often respondents ask for clarification before providing social security numbers and to code the cases accordingly so we can look at differential refusal rates, for example. Again, exactly what is said (by respondents and interviewers) typically when respondents do ask? Legal and procedural issues abound here, too. For example, how long, even assuming informed consent, can the consent be treated as binding? Social Security practices with outside researchers (when they obtain consent to gain access to individual records) is to treat the consent as binding potentially only once; thus, requests for information on the same subjects may require a renewal of the consent. Signed consent agreements are also required of outside researchers. Such a requirement has never been imposed, say, in Census Bureau surveys, but should it be? If it were, what would be the costs of such a practice in interview time, reduced response, and cooperation generally?

Public perception concerns deserve to be examined in depth. To what extent are we already violating the public's sense of the social customs within which statisticians are supposed to work? The public opinion polling

results reported in Gonzalez and Scheuren (1965) need to be followed up. It does not seem defensible simply to speculate about whether this or that approach to data linkage would be acceptable to the public. While we can never use opinion polling to answer all the many specific issues that exist here, much can be done. Of particular interest may be the extent to which the public knows or assumes such linkages take place now and for what purposes; the perceived legitimacy of actual and perceived purposes; whether statutory or contractual prohibitions against efforts at reidentification would be seen to be adequate; and so on.

We do not believe that an entirely satisfactory technical solution to the reidentification problem is possible; but a great deal more can be done to allow for at least limited release of linked information. The work of Paass (1985) and Smith and Scheuren (1985a) is suggestive here. The line of attack that appears most promising is what might be termed a three-step process. First, "slice" the data up into small enough bits so that each of the "bits" can be adequately masked. (The data, for example, might be divided up into disjoint subsets and for each subset of observations, say, only 2 to 4 different items of administrative data would be provided.) Second, if the slices are chosen appropriately, then one can "splice" back together the complete data set using statistical matching; but in a setting where the conventional--and usually false conditional--independence assumption (e.g., Rodgers, 1984) does not have to be made. Finally, the masking step can add "noise" to the data set in such a way that certain analytic results are either invariant under the noise transformation or correction factors can be calculated and readily applied.

There are some serious losses in this approach. For example, the effective sample size of the linked data items may have shrunk considerably. In any case more research on this problem is definitely warranted, (maybe even if contractual and legal solutions turn out to be eventually possible). Either way, public access to the linked data sets must be seen as a key objective when such studies are undertaken and, to the extent possible, release practices should be as open as with any other data set (Committee on National Statistics, 1985).

Finally, a number of analysis issues have been mentioned which deserve further research, especially in measuring matching errors and adjusting the matched results accordingly. In particular, we need to find a way to escape the historical dilemma that the dissemination and growth of sound theory and practice have been retarded by the perceived uniqueness of many linkage problems (and the customized solutions this perception has led to). The profound nature of the common sense principles upon which good practice is based are not widely enough appreciated. Insufficient attention has been paid to the analysis issues in data linkage systems, perhaps because so much creative energy and financial resources typically go into the linkage steps (Smith and Scheuren, 1985a). It may be too optimistic to suppose that things are now changing, but there is some evidence to this effect in the success of the 1985 Washington Statistical Society Workshop on Exact Matching Methodologies (Kilss and Alvey, 1985). In any case, it is time to stop treating matching as a necessary but dirty business, isolated from other parts of statistical theory and practice.

National Cancer Institute
Vincent T. DeVita, Jr., M.D.

Statement

Cancer is primarily a disease of older people. Over 55 percent of newly diagnosed cases and more than 60 percent of the deaths certified as due to cancer are in people over the age of 65. Thus, as the population ages, even if the risk of developing or dying from cancer does not increase, the absolute number of cancer cases will increase. Therefore, it is of particular importance to assess the changes that are taking place in our population and the effects that these changes will have on the cancer burden.

We know that two forces are at work which will significantly alter the cancer experience of the United States population, in general; the cancer experience of the elderly population, in particular. These forces are: (1) the shift towards an older population; and (2) declining mortality from non-cancer causes of death, particularly cardiovascular disease, which is expected to continue. An expected outcome of these changes is that there may be an increased number of cancer cases, in general, and possibly a shift in the distribution of the types of cancer to those for which existing prevention, early detection or treatment and care resources are not readily available.

A major cancer control and prevention effort is underway by the National Cancer Institute. The goal of this effort is to decrease the cancer mortality rate by fifty percent by the Year 2000. We have identified the following issues which need further clarification to assist us in our planning, problem identification and evaluation.

- More information needs to be collected on concomitant medical problems, including multiple conditions present at death. The presence or absence of chronic health problems affects the cancer diagnosis, treatment, and rehabilitation decision-making by medical practitioners.
- More detailed information on the aged (not only ages 65+ but also ages 75+); perhaps they should be over-sampled periodically on national health surveys. Note that the HANES has an upper cutoff at age 75.
- Health statistics related to health system usage are important on a sex-specific basis since medical problems are different for males and females. For example, medical expenditures, hospital discharges, length of stay, and chronic illnesses should be reported by gender.
- It would be helpful to have compilations of data from other developed countries on health conditions and health expenditures that could be used for comparisons with similar data in the United States.
- The effect of eliminating or reducing specific causes of death and thereby lengthening life expectancy on cancer incidence, survival, and mortality rates.

- The new demands that will be placed on the medical care system by changing the risk factors for multiple diseases.
- Population projections and estimates, taking into consideration changing cause-specific death rates. For example, how do the decreasing mortality rates from heart disease affect population estimates into the Year 2000 and beyond?
- Years of potential life lost to deaths from specific causes and how this will be expected to change as advances are made in treatment and prevention.
- Studies need to be made and reports disseminated regarding the economic consequences of chronic diseases among the elderly.
- Adequate cost data on cancer patients is not readily available; this is because cancer is a chronic disease, and during a patient's cancer lifetime the patient may move, be treated by several physicians and be seen in different institutions. Currently, costs are presented as average annual figures. It would be more useful to have available costs per patient throughout the patient's total cancer experience.

Summit Meeting on Aging-Related Statistics
May 2, 1986
Issues for Discussion

Submitted by the National Center for Health Statistics

What course are mortality and morbidity rate trends for the elderly likely to follow over the next several decades? Is active life expectancy likely to increase as rapidly or more rapidly than total life expectancy? What can be done to postpone the onset of dependency? What are the resource implications of alternative scenarios for the future?

While the depiction of the present situation remains a major function of the statistical system, future oriented questions such as the foregoing are of dominant interest. Epidemiologic and health service models underlie such prophetic endeavors. These models generally require transition parameters, the probability, for example, of moving during a given time from a state of functional independence to a state of dependence. To estimate such probabilities, longitudinal observations are required. We need to track individuals from one situation to the next.

There are currently a number of prospective and a number of retrospective surveys under way that provide information on transition probabilities. However, there remain many gaps. If we had surveys following older patients for periods of time subsequent to hospital discharge, we would be far better situated to assess the impact of prospective payment and generally to model health and health care. Similarly, surveys following cohorts of long-term care institution first admissions could provide the types of information needed for formulating the provisions of insurance and prospective payment schemes. While problems of personal privacy and survey logistics make such surveys difficult, the potential payoff warrants the developmental travail.

The linkage of survey response with administrative records provides a highly cost-effective approach to expanding our longitudinal data base. For instance, linking health assessments from health examination surveys to Medicare records regarding the use of health services increases our knowledge of the course of certain medical conditions and of their resource implications. Similarly, linkage of survey responses to the National Death Index contributes to the identification of factors related to disease risks and prognosis. The facilitation of record linkage, while protecting privacy and confidentiality, should be a key initiative. The current obstacles to information sharing may be more stringent than necessary.

The analysis of cause-of-death trends can be a productive epidemiologic tool. As the proportion of deaths at advanced age increases, problems with the current system of cause-of-death attributions become more apparent. Many of the elderly are afflicted with a multitude of conditions and the attribution of the death to a particular sequence of disease conditions may not be maximally instructive. Consideration needs to be given to the development of improved classificatory systems for the health conditions of the elderly as they affect quality of life and lead eventually to death.

Memory loss and related cognitive deficits tend to become more prevalent with increasing age. Such losses render problematic the precision of survey responses provided by some older people. It is often difficult to tell whether the responses of particular individuals to certain types of questions are of adequate quality or whether it would be preferable to obtain the requisite information from an informant. It may well be profitable to invest in methodological research into the optimal procedures for eliciting information from and about the elderly population.

Intense interdisciplinary collaboration is critical to the establishment, maintenance and appropriate exploitation of statistical data systems pertaining to the elderly. Expertise in geriatrics and medical care must be melded with the social science and statistical orientations of the average survey professional. Health and functional limitations become dominant factors in the lives of many people at advanced ages and their measurement is an imperative if our statistics are to inform public policy. For instance, we cannot develop a sensible long-term care policy unless we are measuring inter-cohort trends in various types of urinary incontinence, tendency to fall, dependence in various activities of daily living, cognitive impairments, etc. Intimate familiarity with elderly people and the physiological, psychological, and social bases of their problems is essential to the appropriate design and interpretation of such measurements.

To this end, we should work to lower barriers between Federal statistical agencies and the scientific community in scholarly institutions, industry and community agencies. There is potentially far more knowledge of value to be gained through the analysis of an agency's statistical output than could possibly be extracted by its own staff. Only by making public use data tapes widely available and encouraging their analysis by non-governmental scientists can we reap the full benefits of our statistical data compilation activities.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date · April 25, 1986

From Director, Division of Intramural Research, National Center for Health Services Research and Health Care Technology

Subject Statement on Vital Issues Related to the Aged

To Cynthia M. Taeuber

The National Center for Health Services Research and Health Care Technology Assessment was informed of the May 2 meeting last week. We were not asked initially and only learned yesterday that a statement regarding policy issues relating to the aging population would be useful. Given the time available, I thought it would be best to send a brief overview of the analytic plan for the 1987 National Medical Expenditure Survey. This plan in presenting the general areas of analysis also presents many of the public policy issues relevant to the population over 65 years.

Donald E. Goldstone, M.D.

National Medical Expenditure Survey

NMES succeeds a series of national medical expenditures surveys, most notably the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES) and the 1977 National Medical Care Expenditures Survey (NMCES). While the data sets from these surveys have served health care policy makers and analysts well, they will be long out of date by 1988, when the first analyses from NMES data will be available. The 1980s have been and continue to be a decade of far-reaching changes in the structure of the health care delivery system and of private health insurance, in the structure and outreach of Federal health care programs, and in the demographic composition of the country. How these changes affect the kinds and amounts of health care Americans use, how they will pay for it, and the implications of further changes in health care policy are questions that NMES data and the analyses based on them will help to answer.

The 1987 NMES is designed to meet the nation's needs for planning and monitoring health expenditures and health insurance coverage. By extending data collection to the institutionalized population, and by oversampling population groups of particular policy interest, NMES will provide a more complete picture of the health care utilization and expenditures of the United States population, and of their insurance coverage, than the 1977 NMCES and the 1980 NMCUES. The resulting estimates will permit evaluating both the overall impact and specific effects of current programs and legislative proposals on cost and utilization across all sectors of the health care delivery system.

The 1987 NMES will obtain data from a national probability sample of the civilian noninstitutionalized population. The NMES sample (approximately 14,000 households) will include oversampling of groups of particular policy interest: blacks, hispanics, the poor and near poor, the elderly, and persons with functional limitations. The NMES Household Survey will be a year-long panel collecting measures of health status, use of health care services, expenditures and sources of payment, insurance coverage, employment, income and assets, and demographic information. A particular focus will be community-based long-term care. Household data will be supplemented by surveys of medical and health insurance providers and by data from Medicare administrative files.

An important feature of NMES will be an Institutional Population Component (IPC), which will survey about 13,000 persons in nursing homes, facilities for the mentally retarded, and psychiatric hospitals and collect data similar to those for the noninstitutionalized household population. The IPC universe includes all persons in these long-term care institutions for any part of 1987. IPC and household data will provide the first composite picture of the nation's needs for long-term health care.

With this institutional component, the analytic potential of NMES will encompass national estimates of health services use, expenditures, and insurance coverage for (1) the entire U.S. civilian population, including the institutionalized; (2) the entire long-term care population, whether residing in institutions or in the community; and (3) institutionalized groups of concern (persons in nursing homes, in facilities for the mentally retarded, and in psychiatric hospitals).

NMES will be administered by the Health Care Financing Administration (HCFA) and the National Center for Health Services Research (NCHSR). The National Center for Health Statistics (NCHS) will assume a supporting role, providing consultation and technical advice as available resources permit. HCFA's primary concern is utilization and expenditure data for persons in the Medicare and Medicaid populations. NCHSR, through the Division of Intramural Research, will use the data for policy research on key national health issues, including the effects of proposals to change patterns and levels of use and expenditures and the structure of private health insurance and federal financing programs. The NMES objectives of the National Institute of Mental Health parallel those of HCFA and NCHSR and additionally focus on patterns of community versus institutional care of persons with and without mental illness and related reimbursement patterns. NMES will be used by the Indian Health Service (IHS) to ascertain all health care resources (IHS and non-IHS) being utilized by American Indians and Alaska Natives, and to estimate associated charges and sources of payment.

The data collection contract was awarded in February 1986. The household survey and IPC surveys will be carried out in calendar year 1987 and 1988, to reflect the experience in 1987. The first published reports are expected in June 1988. It is anticipated that the complete data set will be available for analysis by 1989.

NCHSR

NMES ANALYSIS PLAN

NMES is unique in the depth, breadth, and quality of the information that will be obtained on matters that have been or are likely to be the focus of public policy. In combination with secondary surveys of medical providers and health insurers and with HCFA administrative records, it will provide national estimates of health expenditures and the sources of payment for these expenditures from a national sample survey of persons in households and of persons residing in long-term care facilities.
In contrast to information available from program statistics only, NMES will thus permit comprehensive analyses of data on all public and private sources of financing and health care coverage, including public programs, private health insurance, and out-of-pocket payments by families and individuals. The data base will, therefore, permit assessment of the multiple implications of changes in public and private health care benefits, in methods of financing both health care and insurance coverage, and in various public and private subsidies, income tax exemptions, and employee compensation arrangements.

The NMES panel design of several rounds of interviewing over a full calendar year makes it possible to detect the effect of changes in health status, income, employment, and eligibility for public and private insurance coverage on use of services and public and private expenditures for care. Because data from NMES will be comparable to those from earlier surveys, it will be possible to relate long-term trends to structural change and modifications of public policy.

The analytical power of the data will be enhanced by oversampling groups of particular health policy interest. Oversampling will permit detailed analyses of the effects on the provision and financing of care of demographic changes, such as the increasing proportion of the elderly in the population.

The rest of this statement describes NMES research foci in more detail. Areas of analysis are described under the major headings "Overview of National Health Expenditures," which refer to wide-ranging analyses of basic national health care financing issues, and "Private Health Insurance," "Public Financing Programs," and "Long-Term Care," which represent more closely defined sets of issues of particular policy concern. Across these categories, analyses will cover a variety of population groups, such as the poor, the elderly or the mentally retarded in institutions, as well as examine issues that overlap categories, so as to provide a comprehensive picture of populations and services of interest, relevant financing sources, and issues of general and specific policy concern. Also, the comprehensiveness and flexibility of the NMES data base will permit analysts and policy makers to address new policy issues which will undoubtedly emerge by the end of this decade and the beginning of the next.

OVERVIEW OF NATIONAL HEALTH EXPENDITURES

Because of its large and nationally representative sample, and the range and detail of its data base, NMES can provide a full overview of national health care and health expenditures. The data will be used to analyze:

1. The composition and distribution of national health expenditures with regard to

   General patterns of health expenditures, types of services consumed, sources of care, and variations in expenditures by individuals and families.

   Sources of payment, including public programs such as Medicare, Medicaid, and CHAMPUS; private insurance; and out-of-pocket payments.

   Direct and indirect expenditures for episodes of illness related to relatively common conditions such heart disease, diabetes, and arthritis, and, for the institutionalized elderly, Alzheimer's disease.

2. Trends in the nature and distribution of national health expenditures in the noninstitutionalized population, using data from the 1977 NMCES and the 1980 NMCUES to analyze shifts in the pattern of expenditures, sources of care, and services consumed.

3. Determinants of the use of services and expenditures with regard to

   Social and demographic factors such as the increasing number of elderly Americans, and changes in employment, marital status, and income.

   Methods of financing health care and health insurance.

   The availability, characteristics, and organizational arrangements of both institutional and ambulatory care providers.

The health habits, life styles, and behavioral patterns of individuals and families.

4. Specific population groups whose health care use or expenditures are now or can be expected to be of policy interest, especially the elderly, with regard to

   The relationship between levels of disability and functional dependency in the population 65 and older, the sociodemographic and economic characteristics of this population, and their use of and expenditures for health services.

   The effects of the increasing number and proportion of elderly in the population on the Medicare program, expenditures for long-term care, and the health system more generally.

PRIVATE HEALTH INSURANCE

A major feature of NMES will be the quantity and quality of information on the source, premiums, and benefits of private health insurance in the United States. This information will reflect the restructuring of private insurance now occurring, such as self-insurance, the introduction of multiple options, and a redesign of benefits. The data will be used to analyze:

1. Enrollment and benefit provisions with regard to

   The number and characteristics of persons covered by single or multiple plans and changes in coverage during the year attributable to changes in employment and in marital and dependent status.

   The number and characteristics of privately insured individuals and families who are also eligible for Federal health benefits, such as the elderly, veterans, and dependents of those on active duty with the military.

The number, characteristics, and benefits of those with individual or group coverage, commercial and nonprofit coverage, and coverage through health maintenance organizations or other alternative delivery systems.

The number and characteristics of working and retired Medicare beneficiaries who are also covered by employment-related and/or other private health insurance.

2. Trends in the structure and financing of private health insurance for both the elderly and the younger adult populations, using data from the 1977 NMCES to analyze changes in employer and employee premium contributions, in benefits and options available from employers, and in policy provisions. For the working population, particular emphasis will be given to analyses of how changes in employer premium contributions affect the choice of health insurance benefits (i.e., high or low option plans, individual or family coverage).

3. Factors affecting the purchase, comprehensiveness, cost, and continuity of private insurance coverage with regard to

   Employee wage level, occupation, industry, collective bargaining, and employment status.

   Family structure, family income, and changes in household composition and marital status.

   The overall design of employee fringe benefits and their treatment under the tax code.

   The extent to which continuation and conversion provisions in private health insurance policies limit the loss of coverage during periods of unemployment.

4. The effect of different benefit programs and insurance provisions on use of services, out-of-pocket payments, and total expenditures for health care.

5. Existing or proposed public policies with regard to mandatory or minimum benefit requirements and taxation of employer-paid premiums.

PUBLIC FINANCING PROGRAMS

A major feature of the 1977 and 1980 expenditure surveys was the data on expenditures and use of services under various public financing programs such as Medicare, Medicaid, CHAMPUS, and the Veterans Administration. NMES data will be even more valuable in this regard because of the decision to include the institutionalized population and to oversample particular groups of beneficiaries. The following describes some of the general analyses with regard to all public programs, and then more specific analyses of Medicare and Medicaid recipients.

1. General Analyses

a. The characteristics and behavior of the populations eligible for each of the public programs, including the number, composition, use of services, and expenditures of the population eligible for benefits under Medicare, Medicaid, CHAMPUS/CHAMPVA, the Veterans Administration, and the Indian Health Service. These estimates will encompass all eligible persons, whether served by the program or not, and all expenditures, whether covered by the program or not.

b. Trends with respect to the number, composition, use, and expenditures of persons eligible for public programs.

c. The impact on expenditures and use of services and sources of care that would result from new policy initiatives. The flexible nature of the NMES data will allow modeling of a variety of proposed changes in eligibility requirements, benefit structure, and reimbursement policies. Among the policy issues that could be addressed are

> Changes in the structure of Medicare benefits, including possible changes in deductibles and coinsurance as well as changes in coverage for catastrophic illness.
>
> The implications of gradually increasing the age of Medicare eligibility.

CHAMPUS copayments and benefits and their effects, such as increased deductibles and changes in benefits for dental care and for catastrophic illness.

The implications of various alternative eligibility criteria for care in VA facilities.

d. The impact on expenditures and use of public programs of changes in population structure such as an increase in the proportion of the elderly; in organizational arrangements such as alternatives to nursing home care; and in the structure of the health industry.

2. Medicaid

Both the 1977 NMCES and 1980 NMCUES provided important and unique data on the behavior of the Medicaid population. NMES will permit even closer analysis of this group because it will provide information on Medicaid beneficiaries who reside in institutions. The data will be used to analyze:

a. The characteristics, use, and expenditures of all Medicaid beneficiaries in the institutionalized and noninstitutionalized population with regard to differences between the institutionalized and noninstitutionalized and their relative impact on the amount and composition of Medicaid expenditures, including changes in eligibility status over the course of the year.

b. The interrelationships between Medicaid and Medicare coverage for the poor elderly and those in nursing homes.

c. Eligibility for the medically needy category, and spend-down of personal and family assets.

d. Analyzing how proposed changes in Medicare or Medicaid might affect coverage, costs, and use in the other programs, such as CHAMPUS or VA facilities.

3. Medicare

NMES will provide information on the characteristics of Medicare enrollees, supplementary private insurance, and expenses not reimbursed by Medicare that is unavailable from payment and enrollment records. It will be used for analyses of reimbursement of HMOs for care rendered to Medicare beneficiaries based on the adjusted average per capita cost for Medicare enrollees (AAPCC). The current factors in the AAPCC have been used since 1975 and are based on the Current Medicare Survey, discontinued after 1977.

NMES will provide the first opportunity since the CMS to update the weighting of the AAPCC factors, since NMES will obtain data for both institutionalized and noninstitutionalized populations. The data will be used to analyze the cost and adequacy of private insurance supplements to Medicare, and the extension of employer-sponsored private plans to retirees with regard to

> Trends in access to care, usual source of care, patterns of use of institutional and noninstitutional services, and total expenditures in relation to payment by Medicare and other sources.
>
> Patterns of use and expenditures for health care services of persons covered by both Medicare and Medicaid in comparison with Medicare enrollees not covered by Medicaid. This group is of interest because they are disproportionately likely to be institutionalized and hence disproportionately expensive to care for.

LONG-TERM CARE

1. The Recipients of Long-Term Care

In contrast to earlier expenditure surveys, NMES will contain an institutional long-term care component permitting comparison between institutionalized and community-based long-term care services. The institutional component will also be population based; information will be obtained on a sample of residents in nursing homes, psychiatric hospitals, and facilities for the mentally retarded. These data will complement those from the household sample, where stratification on functional limitation will yield sufficient numbers to analyze community-based services. Together, these data will be used to analyze:

a. The number, characteristics, use and expenditures of the entire population that is functionally impaired and/or receiving long-term care, including

The population in each type of facility by sociodemographic and economic characteristics, length of stay, and functional health status.

The population receiving services in the community.

The likelihood of admission to nursing homes by age, population characteristics, functional health status, and coverage by private insurance or public programs such as Medicare and Medicaid.

Patterns of nursing home utilization, including readmission from acute care hospitals or other nursing facilities.

b. The range of services used by the institutionalized population with regard to

The relationship between the use of services and age, functional health status, length of stay, and source of payment.

Expenditures and sources of payment (including out-of-pocket and private insurance) for all services to the institutionalized, including care by physicians and hospitals outside the institution.

c. Differences between nursing home and community-based populations with regard to

Use of physician and acute hospital services.

The impact of changes in federal and state Medicaid policy on institutional and community-based care and expenditures.

The consequences of Medicare prospective payment on the use of nursing homes, and on community-based support systems and expenditures.

The burden of financing the care of institutionalized persons and how the distribution of this burden would change as policies such as subsidies to encourage use of community-based care are used to discourage institutionalization.

The effects on institutionalization of changes in federal and state Medicaid policies.

2. Persons in Facilities for the Mentally Retarded

Of particular concern to the Health Care Financing Administration is the rapid growth of Medicaid expenditures for persons in facilities for the mentally retarded. NMES will provide the following information and estimates:

a. The number and characteristics of residents in facilities for the mentally retarded, including levels of retardation and functional status, facility characteristics such as type of ownership, size, and certification.

b. The nature of treatment being provided, method of placement, and all sources of payment for medical and custodial care.

c. The charges for providing care in facilities for the mentally retarded and the nature and source of variations between facilities.

d. Expenditures for direct patient care and the use of services by facility and patient characteristics, in particular with regard to

Personal health expenditures, including physician, hospital, and rehabilitation services and drugs not included in facility reimbursement.

NCHSR

Factors responsible for the increase in expenditures and use of services by the Medicaid population residing in facilities for the mentally retarded.

National Center for Nursing Research
Interest in Aging-Related Statistics

The National Center for Nursing Research (NCNR), authorized under the Health Research Extension Act of 1985, was established for the conduct, support, and dissemination of information related to basic and clinical nursing research, training, and other programs in patient care research. The mission of the Center is broad and is further described in this legislation as concerned with the prevention of disease, health promotion, and the nursing care of individuals and the families of individuals with acute and chronic illnesses.

The interests of the NCNR in aging-related statistics are comprehensive and include not only basic demographic and vital statistics on the distribution and characteristics of the elderly population but also data which reflect the economic, social, physical and psychological well-being of older persons.

National Eye Institute, NIH

NEI

ECONOMIC AND EPIDEMIOLOGIC INFORMATION ON EYE DISEASES

Economic Information (Specific for Types of Eye Disease)

Work days lost because of eye related conditions

Occupational changes required

Custodial care requirements and costs

Income tax losses due to blindness

How much do people spend for eye care

What do they spend this money for

Costs for eye care treatments to permit analyses of impact of clinical trials

Determination of expenditures by public for treatments whose efficacy has not been demonstrated

Epidemiologic Information (Specific for Types of Eye Disease)

Incidence and prevalence of eye diseases

Prevalence of eye diseases in nursing home residents

Prevalence of varying degrees of visual impairment

Incidence of complications (short and long-term) associated with new drugs, devices, and surgical procedures

Subject: Statistics on Aging: Vital Policy Issues

From: National Heart, Lung, and Blood Institute

1. Estimates indicate that the number and the proportion of Americans over age 65 will increase markedly in the future. Accurate information on mortality, morbidity and disability from cardiovascular and chronic obstructive pulmonary disease is essential for measuring the magnitude of the problem, determining the need for preventive and therapeutic services and evaluating their impact. Attention should be given to improving the quality of readily available sources of data including death certificates and hospital discharge records.

2. Statistics on the elderly reveal substantial differences in cardiovascular and pulmonary disease rates between men and women, blacks and whites, high and low socio-economic groups and residents of different places within the United States. Explanations for these differences probably include differences in incidence and severity of disease and differences in the quality and availability of medical care. Statistics are needed to quantify more precisely risk factor levels, prevalence, incidence and severity of disease in the population and disability and case fatality rates in affected persons.

3. It is difficult to separate trends in mortality over time and associations between mortality and aging, unless data are presented by year of birth (cohort rates) as well as by year of death. Current patterns in the old-old may not apply in the future since succeeding generations have lived through very different experiences. Predictions for the future would be enhanced if cohort data were available.

4. Attention must be given to competing causes of death in order to appreciate trends and predictions for cardiovascular and pulmonary diseases and for life expectancy.

5. The racial composition of the U.S. population is changing as a result of immigration and differences in reproductive patterns. Statistics will be needed to show how these and other demographic changes affect mortality, morbidity and disability among the elderly.

NIA Issues for May 2, 1986 summit meeting on Federal Statistics for the elderly

The National Institute on Aging was established by Congressional mandate in 1974 for "the conduct and support of biomedical, social, and behavioral research and training related to the aging process and the diseases and other special problems and needs of the elderly". Within the tripartite biomedical/social/behavioral legislative mandate of the Institute, two of its constituent units have primary concern with Federal statistics on the elderly: the extramural Behavioral Sciences Research Program (BSR), and the intramural Epidemiology, Demography and Biometry Program (EDB).

The BSR Program supports research, training and database development across a wide range of disciplines including demography, sociology, epidemiology, economics, and psychology. Important priorities within BSR include such areas as productivity in the middle and later years, the impact of the changing age composition of the elderly, economic well being of the elderly, the effects of gender on health and longevity, health and effective functioning, research methods, and the Oldest Old (those age 85 and over -- an Institute wide congressionally mandated priority). Providing adequate data resources for the extramural scientific research community is an important BSR function, and BSR supports a data archival center at the University of Michigan (see appendix), and through interagency or cooperative agreements (see appendix) also contracts with other agencies in order to develop databases such as the International Database on Aging (Bureau of the Census) and the Linked Longitudinal Study on Aging (National Center for Health Statistics).

The intramural EDB program collects and analyses data in the areas of epidemiology, demography, and biometry. Major studies underway include the NHANES I (National Health Examination Study) follow-up, the Framingham Dementia Study, the Macroeconomic-demographic model, the Last Days of Life Study, and the EPESE longitudinal studies (Established Populations for Epidemiological Studies on the Elderly) in four communities.

1. The appropriate sample size, sample design, and age break reporting are generally inadequate within major federal surveys that are especially relevant to the elderly population.

Nationally representative surveys such as the National Health Interview Survey (NHIS), The National Medicare Expenditure Survey (NMES), the Survey on Income and Program Participation (SIPP), and the Current Population Survey (CPS) often end up with inadequate numbers for many types of analyses of the oldest old (those age 85 and over). The CPS sample of the oldest old is too small to be used to produce reliable and reasonably precise estimates of the trends in poverty within important subgroups of this age group (for example, there are only N=421 men 85+ in the survey). In the NHIS, for example, the sampling design results in a comparatively vast collection of data on the healthy middle aged and a sparse dataset on the elderly population which has the heaviest burden of morbidity and disability, and receives a large fraction of all transfer payments. This sampling design artifact stems in part from the use of a CPS-based Bureau of the Census sampling frame that is oriented toward coverage of the labor force population. At the very least, consideration should be given to the use of supplementary samples of the elderly from such administrative files as Social Security Administration.

The rumored reductions in sample size in, for example, SIPP and the NHIS will exacerbate an already severe problem. The SIPP panel size, for example, was N=518 for those 85+ in 1984, N=372 in 1985, and is likely to be reduced to N=319 in 1986 (the corresponding numbers for males 85+ are N=149, N=106, and N=90).

The old old and the oldest old are often invisible because data is often reported only for those 65+. The practice of reporting statistics for the elderly as a whole obscures the very real heterogeneity in wealth, function and need within the elderly population. While more data is being reported by subgroups of the elderly, considerably more effort needs to be paid to this problem.

Coverage of the elderly population is often incomplete because household surveys do not include information on the elderly living in institutions, and sometimes do not adequately include the elderly living in certain quasi-institutional living arrangements within the community.

Action possibilities:

As a general principle, given the expense of major Federal surveys, Federal Agencies should coordinate activities in order to support data gathering activities that serve multiple interests. Agencies might explore co-funding surveys and piggybacking opportunities.

Attention should be given to increasing the sample size through changes in the sample design (e.g. oversampling elderly households, changing the within-household selection algorithm, and sampling from administrative records such as Medicare Files to augment the household sample).

If cutbacks in sample size are needed because of budgetary constraints, then consideration should be given to the proposition that the reductions should not be proportional across all age breaks.

Agency heads should require justifications for not reporting data relevant to the entire elderly population by 5 year age intervals.

2. The quality of data on the elderly is often poor.

A number of problems have resulted in the data on especially the oldest old being of suspect quality. For example, recent NIA-funded studies at the Bureau of the Census have found that the number of centenarians is more likely closer to 16,000 than to the 32,000 actually enumerated (while an NIA funded grant project estimated the likely number to be between 10,000 and 16,000). Such major inaccuracies can play havoc with the calculation of, for instance, the mortality rate of that group -- depending upon the census number used, the "true" mortality rate would be understated by about half. The problems stem not only from inadequate editing and allocation problems but also from problems inherent in interviewing individuals with cognitive and hearing deficits, and from obtaining reliable information from proxies and administrative records. Special interviewing techniques are probably needed to obtain reliable and valid information (such as medical histories) from the elderly with cognitive or sensory impairments.

Action possibilities:

Federal Agencies might collaborate in the development of improved techniques for interviewing the old with sensory and cognitive impairments. For example, there might be increased coordination among NCHS which is considering setting up a cognitive lab to improve the quality of survey interview data, NIA which has called for methodological studies that will lead to improved data on the oldest old collected though interviews, proxies, and administrative records, and the Bureau of the Census which is preparing for the 1990 Census.

3. There is a great need for 1) comprehensive, and 2) longitudinal data on the elderly population.

Co-morbidity is a salient feature of the elderly, and especially the oldest old, population. Rates of institutionalization, for example, are dependant upon multiple factors including functioning, specific disorders, financial status, housing characteristics, and available social resources. Many surveys have in depth information on a single area but are weak on other important topics. The CPS, for example, collects detailed information on income, but not on wealth or functioning. The American Housing Survey, rich on housing conditions, collects virtually no information on the functional disabilities of the occupants.

The answers to many important questions, such as the determinants of poverty among the oldest old and minority elderly, require longitudinal data in order to understand the dynamics of the different paths into poverty. Epidemiological studies that search for earlier life antecedents of chronic diseases that are prevalent among the elderly, such as the dementias, could be aided by lifelong records of medical, residential and work histories. There are also many surveys and epidemiological studies, some quite old, which are not now slated for follow up, but which could provide valuable longitudinal data on the elderly.

Action possibilities:

Agencies could cooperate in piggy-backing modules on each other's surveys.

Survey results from cross-sectional surveys such as the NHIS, the American Housing Survey (AHS), or CPS could be used as the sampling frame for subsequent studies -- this might involve revision of Title 13 Privacy Act legislation or changes in OMB regulations.

Enhanced opportunities for linking to, or sampling from, administrative records (such as Medicare Files, Social Security Administration earnings records, etc.) should be explored as this could greatly expand the comprehensiveness and longitudinal dimension of survey data.

Possibilities for following up surveys or studies that are not now slated for follow up should be identified (and information needed for following individuals should be routinely included in relevant surveys). The longitudinal Study on Aging (LSOA) in which NIA is funding the NCHS and Bureau of the Census to follow up the elderly from the 1984 NHIS Supplement on Aging and link the file to the National Death Index and Medicare Records is an example study. Examples of other studies that could provide enormously useful data at very low marginal cost if followed up include the National Nursing Home Admission Cohort, the National Long Term Survey, and the Retirement History Survey. Consideration should be given to funding such studies through the grant mechanism (including cooperative agreements) rather than solely through interagency agreements.

Increasing use should be made of long running longitudinal studies designed to study a single disease (e.g. the Honolulu Heart Study, the North Karelia Study, etc.) for aging studies (the Framingham Heart Study "spin-offs" into the Framingham Disability and Dementia Studies are good examples of this possibility).

Data gaps that might need interagency coordination, such as the prevalence of cancer survivors, or the life or active life expectancy of those with chronic impairments, should be identified and filled.

4. Many Agencies do not fully analyse the data they collect and are slow to make it available to outside researchers.

There are numerous examples of data sets that have been made available to the extramural community only after long delays (e.g., the surveys by the Bureau of Labor on private pensions and by NCHSR on medical expenditures). Further, while many Agencies do release data to the NTIS, the data sets are not well supported and are difficult to use.

Action possibilities:

Where confidentiality is the major barrier Agencies might copy the NIA-Census arrangement under which outside investigators apply for F32 and F33 NRSA fellowships in order to spend a year working in a collaborative arrangement within the agency. The IPA mechanism could be used to allow scientists from, e.g., NCHS or HCFA to join the NIA EDBP Program to work on data from the Established Population Epidemiological Studies of the Elderly (EPESE).

Agencies might reduce their servicing load by helping the NIA support the National Archive of Computerized Data on Aging at the University of Michigan, Ann Arbor. NIA might co-sponsor data user workshops with other agencies.

Intramural databases useful for aging research (e.g., the Framingham based studies would be useful for the NIA Forecasting RFA) could be made available to the extramural community.

5. There is a need for increased co-ordination of data gathering and data analysis functions for the elderly population.

The current NAS Panel on Health Statistics for an Aging Population is considering the need for the increased need for the coordination of statistical policy, data-gathering and analysis of data on the elderly and will most likely recommend increased co-ordination. OMB has not preformed this task adequately. While there are a number of possible agencies/committees that might be able to perform certain aspects of this task, all have a significant number of limitations. For example, AOA currently does not have the personnel for the task; the Federal Forum on Aging can help on the informal level, but is not appropriate for formal coordination; the Federal InterAgency Committee is not suitable as presently constituted; the Bureau of the Census does not have adequate expertise in the area of health and vital statistics, and NIA does not have the personnel time that would be needed to perform these tasks.

While the attractions of increased coordination are most evident (decreased duplication and cost, increased output, etc.), there are also a number of possible drawbacks, not the least of which are more unproductive committee hours, everyone wanting their "angle" in and thus destroying the integrity of an interview, adding to the cumbersomeness of the approval process in a time when rapid action near the end of a fiscal year is often necessary, and the lack of representation of the extramural scientific community which often does the most in-depth and sophisticated analyses of the data.

Action possibilities:

Agencies such as NCHS and the Bureau of the Census that are involved in major data collection or analysis on the elderly population should set up offices on aging to coordinate these functions.

Agencies should give consideration to publishing an annual or biannual report on the data on the elderly to alert a) policy makers to developing trends and data gaps, and b) extramural scientists to new data sources (the NIA is funding the Bureau of the Census and the NCHS to produce such reports).

If a coordinating group is established, consideration should be given to the representation of extramural scientists (e.g., through the National Academy), and avoiding unwieldy numbers and procedures.

6. The need for increased research and training in the demography and epidemiology of aging, as well as for cross national research.

Many contributions of social science such as sampling methodology, survey methodology, and the methods for the analysis of complex longitudinal data sets are ignored when social science research is criticized as soft or trivial. There is a powerful interdependence between Federal data on the elderly population and demographic and epidemiological. For example, social, economic, and medical demography, and what might be called population epidemiology, are all interlinked, and are all heavily dependent upon Federal data. On the other hand, Federal Agencies depend upon these and other disciplines for assistance in developing surveys and appropriate methodologies for analyzing the data. The pool of trained researchers in these areas is too small for current needs.

While some disciplines are content-blind, it is simply not realistic to assume that, for example, demographers trained in the area of fertility research can be adequately sensitive to the special problems of research on the elderly.

Cross-national demographic and epidemiological research is probably an orphan in today's funding environment. Yet, this situation ignores the value in discovering, for example, major geographic variations among the elderly in disease specific mortality, morbidity, and functioning.

Action possibility:

Adoption of a resolution or sense of the meeting in support of the need for additional demographic and epidemiological training in aging research and training to be sent to Council, Director NIH, and appropriate Congressional contacts.

Agencies should increase collaboration in order to develop cross-national data sets. For example, the NCHS should join the NIA/Bureau of the Census effort in creating an International database on aging.

Other agencies should identify research needs (methodological or substantive) and where appropriate, NIA should take the lead in developing and funding the research, cooperatively if possible.

APPENDICES

National Archive for Computerized Data on Aging (NACDA)

Through a grant to the University of Michigan, the NIA Behavioral Sciences Program supports the National Archive for Computerized Data on Aging (NACDA), which provides survey data on aging to researchers around the world for secondary analyses. Since the collection of data, especially large national longitudinal surveys, is expensive, the NIA has encouraged the sharing of data sets. No single investigator or group of investigators can completly mine such data. Consequently, making the data available to other researchers greatly increases the cost-effectiveness of research.

Behavioral Sciences Research Program Interagency Agreements

Project Name: International Database on Aging (Interagency Agreement with the Bureau of the Census)

This agreement provides funds to the Bureau of the Census to develop an International Database on Aging. The Database will include demographic, social, and economic information on foreign populations tabulated by age. A public use data tape of the Database has been released to the scientific community and for archiving at the National Archive of Computerized Data on Aging; and a monograph on the Database will be prepared in FY 1986.

Project Name: 1980 Census Tabulations A and B (Interagency Agreement with the Bureau of the Census)

This agreement provides funds to the Bureau of the Census to prepare special tabulations and public use tapes on the 1980 Census. The tabulations will be done by five-year age intervals and will be deposited in the National Archive of Computerized Data on Aging. Tabulation A will be on Summary Tape File Number 5, while Tabulation B will be on the full Census file and will include tabulations suggested by researchers in the community.

Project Name: Evaluation of the Quality of 1980 Census Data on the Elderly (Interagency Agreement with the Bureau of the Census)

This agreement provides funds to the Bureau of the Census to evaluate the quality of the data on the elderly. The study makes use of the special post Census enumeration survey.

Project Name: Longitudinal Study on Aging - the "LSOA" (Interagency Agreement with the National Center for Health Statistics)

A sample of respondents from the 1984 Health Interview Survey's Supplement on Aging will be reinterviewed in 1986. The sample will consist of all those over age 80 plus, and one-half of those aged 70-79. The reinterview will provide information on changes in functional status, residence and living arrangements. The tracking of the mortality experience of the Supplement on Aging through the National Death Index will be coordinated with the linked data file that will be developed. Attempts will also be made to link Medicare files from HCFA to this database. The data files will be deposited at the National Archive of Computerized Data on Aging.

Project Name: Mortality Followback of the 1984 HIS Supplement on Aging Respondents (Interagency Agreement with the National Center for Health Statistics)

This agreement provides funds to track the mortality experience between 1984 and 1989 of respondents to the 1984 HIS Supplement on Aging.

Project Name: NCHS Data Tape on the Elderly (Interagency Agreement with the National Center for Health Statistics)

This agreement provides funds to the National Center for Health Statistics to prepare a special public use data tape on the elderly population. The data tape will combine core health items from 1969 to the present from the various NCHS surveys including the NHIS. The data will be arranged so that synthetic cohort surveys are possible. Where necessary, data will be pooled across years to allow for five-year age breaks. The data files will be deposited at the National Archive of Computerized Data on Aging.

Project Name: Health Measures for the Panel Study of Income Dynamics (Interagency Agreement with the National Science Foundation)

This agreement provides partial funding for the 1986 wave of the PSID (University of Michigan), specifically for the addition of a ten-minute segment to the interview of the heads-of-household and special 25-minute interview of their spouses. The resulting data will be made available to intra- and extra-mural scientists through the National Archive of Computerized Data on Aging.

Pending Interagency Agreements

Project Name: Foreign born elderly

The Bureau of the Census will prepare a special data tape of detailed tabulations (with five year age breaks where possible) of the foreign born elderly in the 1980 Census. The data tape will be archived at the University of Michigan NACDA.

Project Name: Bureau of the Census Annual Data Report on the Elderly.

The Bureau of the Census will prepare an annual report on data on the elderly. The report to be about 20 pages will abstract the most recent data on the elderly population in a number of areas. Every year the Report will highlight one topic for special coverage.

Project Name: NCHS Biannual Report on the Health and Vital Statistics of the Elderly.

The NCHS will prepare a report on the most recent data on the health of the elderly and their mortality and divorce statistics.

Selected Epidemiology, Demography and Biometry Projects

Title: Followup of National Health and Nutrition Examination Survey I (NHANES I)

The purpose of this project is to design and complete a followup of persons examined in the HANES I to study how factors previously measured relate to the health conditions that have developed since the survey. The three major areas for prediction of outcome are 1) nutrition 2) risk factors for chronic disease and 3) health care utilization. The survey will have a household interview including self-reporting of health conditions, utilization of health services and behavioral and social status plus some physical measurements as blood pressure, height, and weight.

Title: Established Populations for Epidemiologic Studies of the Elderly (EPESE) - Yale University, University of Iowa, Harvard University, Duke University

The purpose of this project is to conduct epidemiologic investigations in a community to develop new knowledge concerning the medical and social factors in health and diseases of the aged. Studies are to be completed on problems of pain, vision, hearing, sleep, drug use, constipation, social support and other pertinent areas.

Title: Senile Dementia: Natural History in a Noninstitutionalized Population

The objective of this study is to describe the course of general health and cognitive decline in a group of SDAT victims and controls.

Title: Dementing Illnesses in the Framingham Heart Study

Objective: Current funding supports the continuing neuropsychological and neurological evaluations of all study participants suspected of dementia, the gathering of information related to the diagnosis of dementia from family members of possible cases, data managing, and statistical analysis related to the information generated by these examinations and interviews, and coordination of the dementia/aging disability components of the study.

Title: Survey of the Last Days of Life

The purpose of this project is to collect descriptive data on the last days of life for a community sample of persons age 65 and older whose deaths occurred in a one-year period. In addition to providing specific data on basic events and circumstances surrounding death, the study will provide lifetime prevalence data for a set of conditions related to, but not necessarily causing death. The new knowledge gained from this study will be extremely valuable in relieving the burden of anxiety on family, friends of the dying person, and to providers of care.

NIA

Title: Updating and Revising the Macroeconomic-Demographic Model

The objective is to update and revise the MDM. This will involve both re-estimation and other revisions to the equations and structure of the model in order to update the model from newly available data and from institutional changes in Federal programs. The end result will be an updated new base case for the computer simulation model that can be used for analysis of policy change and population aging. This work shall be consistent with the ongoing modeling.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
National Institutes of Health

Memorandum

Date April 21, 1986

From Director, NICHD

Subject "Vital Few" Issues on Aging-Related Statistics
Meeting - May 2, 1986

To T. Franklin Williams, M.D.
Director, NIA

Two issues of major importance to NICHD research programs are encompassed by this conference on aging statistics: mental retardation in the elderly, and allocation of resources to the elderly in comparison to children by families and government.

There is some evidence that the mentally retarded as a group are living longer. This gives rise to the need for information on this group over the life course. Because it is a small group, only a very large sample will yield enough cases to support research. Historically, mental retardation research has focused on the population under age 21. The number of reported mentally retarded persons declines after school age and tracking of these persons diminishes as they pass out of school surveillance. It is generally understood that the number of older mentally retarded and developmentally disabled persons has grown progressively as a result of increased longevity and population size. Rough estimates put this population at between 200,000 and 500,000 persons in the United States. Statistics on the aged MRDD population are difficult to achieve for lack of accepted uniform definition. Supplemental Social Security (SSI) files should provide a rock-bottom estimate. Vital issues for the aging mentally retarded include guardianship, insurability, and provision for health care.

From a demographic perspective, we are interested in how the generations interact with one another to solve dependency problems. We are interested in how public programs and private institutions, such as the family, operate to allocate resources among the age-related dependency groups, i.e., the aged and children. We are interested in both socioeconomic data and health-related data that pertain to how well individuals in successive generations are nurtured. From the standpoint of NICHD, we are primarily interested in how well children are doing as a major dependency group in comparison to the aged. Therefore, sets of parallel statistics need to be developed to effect the comparisons. Furthermore, we are interested not only in how well public programs allocate resources to meet the needs of these two major dependency groups, but also how families make their decisions as to resource allocation. We believe that this is one of the most important public policy issues facing the Federal Government in the eighties. The essence of the research problem really reduces to research among the various age groups with respect to key measures of socioeconomic wellbeing, health, and human development and research on the investments different generations make in each other. What is inhibiting meaningful research is a parallel set of statistics that would accurately enable us to compare the wellbeing of the aged with the wellbeing of children, and data on public and private investments in human resources across the life course.

Duane Alexander

Duane Alexander, M.D.

cc: Mr. John G. Keane

Statement of the National Institute on Alcohol Abuse and Alcoholism on Aging Related Issues and Research Needs*

Until very recently, little attention has been focused on alcohol problems in the older population. According to tradition and the results of the few available research findings from both the United States and abroad, drinking tends to begin in the teens, peak in the young adult years, decrease somewhat in the middle years and decline sharply in old age. While this may be a true reflection of reality, a number of alternative explanations may account for or contribute to this apparent late-life consumption decline. As examples, many chronic alcoholics do not survive into old age but die prematurely of some alcohol-related cause including car accidents, cirrhosis of the liver, cardiovascular problems, etc. While these chronic consumers are included in the numbers/proportions of younger groups, they may not be alive to contribute to the count of older drinkers. The majority of the older population and also the majority of the nation's abstainers are older women. Clearly they also contribute to this apparent decline in consumption.

Most available studies comparing alcohol consumption across age groups are of a cross-sectional rather than a longitudinal nature; and gerontologists have learned well how invalid the results of cross-sectional studies can be for examining trends in the older population. Further, most studies have included the elderly as a peripheral part rather than a primary focus. Many measurement tools constructed and appropriate for the general population may likely yield invalid findings when used with the elderly. The aging system is considerably more sensitive to alcohol than is that of younger generations. Given the same amount of alcohol and all other factors being equal (i.e., body weight), an older person will experience greater effects than will his younger counterpart. General population instruments, such as those measuring quantity/frequency, when used with the older population may therefore underestimate the incidence and prevalence of late life consumption. In view of these and other potential confounds, it is not unreasonable to question our existing data on older people and alcohol.

Current estimates are that between 2 and 10 percent of the older population have alcohol-related problems. Even if these estimates were accurate, this is approximately the same prevalence as that of the

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*While the Institute acknowledges the existence of critical aging-related issues of a more general nature, this statement addresses only those related specifically to alcohol and aging.

NIAAA

general population, and a large absolute number of older persons. With the projected increase in size and longevity of the older population, and with the lack of a Prohibitionist culture and value system during their developmental years, it is reasonable to expect that tomorrow's cohort of elderly will consist of a much greater number and proportion of users and abusers. The social acceptance of female drinking also should be reflected in tomorrow's numbers.

Because so little information currently exists on elderly alcohol abuse, there is a critical need to collect data on a vast array of topics through well designed elderly-appropriate studies and instruments. The following are only a few of the critical issues that need investigation.

An important first step is to gather basic data on drinking patters over a lifetime through well designed longitudinal rather than only cross-sectional studies. From such a data base a number of important issues could be examined including:

- A more realistic measure of the incidence and prevalence of alcohol abuse in older people;
- Whether alcohol consumption does in fact taper off significantly in old age;
- Whether incidence and prevalence differ with various demographic variables such as sex, marital status, living arrangements, SES, health status, race, culture, ethnicity, educational level, age (young-old vs. old-old), number, quality, proximity and frequency of contact with confidants comprising an older person's support network, etc.; and,
- Whether late life heavy or problem drinking can be predicted by drinking patterns in younger years.

Determining what factor or cluster of factors may make an older individual at high-risk for alcohol problems clearly is a crucial issue for investigation. Some have suggested that various critical life events such as retirement or loss of spouse may precipitate alcohol problems. Examining data on drinking patterns pre and post such life events may provide insight into risk factors and lay the groundwork for more specific investigation.

The literature refers repeatedly to two basic categories of older problem drinkers: those of early onset (chronics) and those of late onset (often called reactive drinkers). Early onset refers to those who exhibited heavy or problem drinking at young ages and continued, intermittently or continuously, throughout their lives. Those of late onset supposedly began problem drinking in old age presumably as a reaction to one or more of the life stresses more frequent in the later than younger years such as loss of job, income, spouse, health, mobility, residence, social status, support network, societally defined beauty, etc. Despite their wide use and acceptance, these constructs have not been verified empirically. We need to determine whether these two categories of late life abuse actually do exist and if a person who did not customarily choose alcohol as a coping mechanism in his/her younger years would in fact readily adopt alcohol as a coping device in the later years.

Mortality rates of elderly problem drinkers may be even more enigmatic than those of younger generations. Far too often alcohol caused/related deaths are reported as anything but that. Cardiac arrest and liver dysfunction are two prime examples. While the organ may in fact fail, alcohol is seldom reported as a causal or contributing factor. Physicians and coroners alike need to include alcohol abuse in death records when it is indeed appropriate; and more realistic estimates of old age mortality rates associated with alcohol are clearly needed.

An especially critical problem is the non- or misdiagnosis of late life alcoholism. Because of similar symptoms such as irritability, mood swings, confusion, forgetfulness, memory and cognitive impairment, etc., alcohol problems can easily be confused with other conditions such as depression, malnutrition, overmedication or drug interaction, and Alzheimers Disease. Perhaps of particular concern is the misdiagnosis of alcoholism as Alzheimers Disease. This Institute has had numerous calls from various parts of the country from people, especially mental health professionals, who suspect and are concerned that many older persons who have been institutionalized with a diagnosis of Alzheimers Disease may instead be in advanced stages of alcoholism. The latter, an initially treatable condition, if diagnosed as Alzheimers and left untreated, can in fact result in permanent irreversible brain damage. There is a great need to obtain accurate estimates on alcohol-related misdiagnosis and treatment facility/program misplacement of older persons.

Informal observations and anecdotal information suggest that "accidental" or "inadvertent" alcohol problems may develop in residents of retirement centers. Speculation suggests that this phenomenon may result from the increase in frequency of the types of social occasions at which these residents customarily engaged in social drinking during their preretirement years. As an example, in any one day, especially at the more exclusive retirement communities, a resident may participate in a brunch, lunch, bridge or golf game, happy hour, dinner, party, etc. If the residents had been accustomed throughout their lives to engaging in social drinking during such occasions, they may well continue this trend into their retirement years. The increased frequency of such activities, particularly in retirement centers with a strong emphasis on recreational and leisure activities, could result in an older resident's drinking - even minimal amounts - steadily throughout the day. In short, it is important to determine whether retirement center residents tend to consume more alcohol than do other elderly, or then they themselves did prior to relocating to the retirement community.

Another living environment important for study is low income congregate housing. Staff of public housing facilities frequently report excessive alcohol consumption among their residents. This is not to imply a

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causal relationship between problem drinking and public housing, but merely to assert the need to determine for whom and where late life alcohol problems exist so that intervention and prevention efforts can ensue.

Another crucial area for investigation pertains to the interactive effects of alcohol and drugs (prescription and over-the-counter) including cough syrups which are often overlooked. The interactive effects of alcohol and only one drug can, at minimum, increase the potency of both and at worst, result in death. Since most older individuals consume approximately four different medications, the risk of alcohol/drug interaction is great. Even obtaining data on their awareness of such potential health and life-threatening problems would be a valuable contribution.

The National Institute on Alcohol Abuse and Alcoholism Division of Biometry and Epidemiology (DBE) is currently studying late life drinking patterns by analyzing the data from the National Health and Nutrition Examination I Epidemiologic Followup Study (NHEFS). This study, conducted from 1982-1984, was a longitudinal followup of 14,407 individuals 25 to 74 years of age who participated in the National Health and Nutrition Examination Survey (NHANES I) during the years 1971-1974. Since both the initial and followup studies contained alcohol questions and since the followup study selectively oversampled the elderly, this data base lends itself well to examination of alcohol-related issues in the elderly. DBE is currently examining patterns of alcohol use, associated health problems and mortality among the members of the cohort age 55 and older at the time of the initial examination. In the future, the Division plans to continue to participate in the Epidemiologic Followup Study which is an ongoing, continuous followup of the elderly portion of the initial study group, as well as periodic followup of the entire study group.

In addition, the National Institute on Alcohol Abuse and Alcoholism is encouraging researchers in the field to submit applications related to alcohol and aging. One of the Institute's National Research Centers is focused on aging and alcohol which was designated as a priority in the respective announcement.

In November 1983, the National Institute on Alcohol Abuse and Alcoholism together with the National Institute on Aging sponsored a major forum on alcohol and aging which included the discussion of relevant data from the NIMH Epidemiological Catchment Area Studies. While these various efforts are significant, there remains a great need to gather additional data on a number of unanswered critical questions pertaining to alcohol and the elderly.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
National Institutes of Health

Memorandum

Date April 30, 1986

From National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS)

Subject Statistics on Aging: Vital Policy Issues

To Director, National Institute on Aging
Director, Bureau of the Census

The majority of Americans affected with arthritis and musculoskeletal disorders are elderly. The principal forms afflicting them are osteoarthritis (or degenerative joint disease), rheumatoid arthritis and osteoporosis. In the NHANES I survey, physician-verified evidence of osteoarthritis and rheumatoid arthritis were found in 76 percent of males and 85 percent of females aged 65 through 74 examined. Moreover, an estimated 90 percent of white women aged 75 and older have moderate or severe osteoporosis of the dorso-lumbar spine as demonstrated by x-ray examination.

The majority of skin diseases are more prevalent in the older age groups. These include conditions such as severe dry skin and the development of neoplastic lesions. According to data from the NHANES I, approximately one-third of the nation's adult population have a skin disease significant enough to warrant examination and treatment by a dermatologist.

With few exceptions, arthritis, musculoskeletal disorders and many of the skin diseases are of the chronic debilitating form, of generally unknown etiology, for which long-range management and secondary prevention in some are the main forms of medical intervention. Consequently, it is extremely important that providers of care and planners of services be updated on the composition and status of the affected populations.

Osteoarthritis is freqently viewed by both many patients and health care providers as an inevitable and relentless consequence of aging. This misinterpretation of the disease can lead to needless suffering as the elderly victim fails to seek or receive treatment which may relieve symptoms, control disease, and prevent deformity and disability.

With respect to skin disorders, NHANES data suggest that many individuals, particulary in the older age groups, do not seek prompt or appropriate care for certain conditions that become or may become malignant. These conditions may be associated with sun exposure. This exposure has been much greater for individuals born since World War II; this is likely to become an even greater problem in the decades to come.

The newly created National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) was legislatively established in November 1985. Congress mandated, through that legislation, the establishement of an NIAMS Data System "for the collection, storage, analysis, retrieval, and dissemination of data derived from patient populations with arthritis and musculoskeletal and skin diseases. This includes, where possible, data involving general populations for the purpose of detection of individuals with the risk of developing arthritis and musculoskeletal and skin diseases."

The extramural NIAMS program supports epidemiology research, training and database development for the arthritis and musculoskeletal programs. The skin diseases program is in the process of implementing its first registry. The NIAMS Epidemiology and Data Systems Program has emphasized the development of data resources for the extramural scientific research community. Many of these activities on data development have been carried out in constructive collaboration with the NIA intramural Epidemiology, Demography and Biometry program. The NIAMS is particularly concerned with the following data resource issues:

1. It appears that major federal surveys have generally undersampled the more physically disabled. The use of age caps, omission of individuals who were unable or less willing to commute to away-from-home screening sites and the exclusion of institutionalized individuals have made it extremely difficult for investigators to measure the overall burden of arthritis, musculoskeletal and skin diseases in various subgroups.

2. Very little population-based longitudinal data currently exist for arthritis, musculoskeletal or skin diseases. Currently, there is no major data source where the same joint x-ray on the same individuals may be examined at more than one point in time.

3. No data sources currently exist to monitor the possibly changing incidence of diseases, such as rheumatoid arthritis, in various population subsets.

4. Disease definitions themselves need to be refined. Conditions occurring as a "natural concomitant of aging" need to be differentiated from functional and pathologic changes characterized as disease states.

5. Data sources are needed to examine sociological factors associated with health care for arthritis and skin diseases in the elderly as they pertain to entry into the medical care system.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20205
Building : 31
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April 15, 1986

T. Franklin Williams, M.D.
Director
National Institute on Aging
National Institutes of Health
Building 31, Room 2C02
Bethesda, Maryland 20892

Dear Dr. Williams:

Thank you for your letter on the upcoming Summit Meeting on Aging-Related Statistics. The coordination of data needs and opportunities is essential in many fields, and aging is a good place to start.

From our Institute's perspective, data on the oral health status of the senior citizens are of primary import. The results of our current Adult Oral Health Survey should provide us with an initial perspective on this issue for those elderly who frequent senior centers. However, the comparable data on the general health status of these citizens, and the oral health and general health status of all the subgroups of elderly, is necessary. In addition, data on the utilization of health care services (including dentistry), and expenditures for these services (including source of payments) by senior citizens in all subgroups would be extremely useful. Finally, information on the type, number and distribution of appropriate manpower would be critical for the planning of appropriate research. A copy of the issues statement sent to Dr. Keane is enclosed.

I have asked Dr. Dushanka V. Kleinman, Special Assistant to the Associate Director for Program Coordination, Epidemiology and Oral Disease Prevention Program, and Dr. L. Jackson (Jack) Brown, Acting Chief, Planning and Evaluation Section, Office of Planning, Evaluation and Communications, to assist me at the May 2 meeting. With the multitude of organizations involved in collection aging-related statistics, it will be extemely useful to discuss appropriate coordination mechanisms.

Sincerely yours,

Harald Löe

Harald Löe, D.D.S., Dr. Odont.
Director
National Institute of Dental Research

Enclosure

National Institute of Dental Research

Issues Regarding the Aged

The interest of the National Institute of Dental Research (NIDR) in issues regarding the aged is particularly well documented in the attached research agenda, a product of a collaborative effort between the National Institute on Aging, the Veterans Administration and the NIDR. This agenda specified research recommendations in six major areas: epidemiologic studies; investigations of oral tissues in aging; characterization of oral health in relation to general health; pursuit of the attitudes and behaviors affecting oral health; studies of utilization of home care and health services; and research on clinical decision-making and treatment efficacy. In addition to these areas, the three organizations are interested in the availability of trained research manpower and educators who could address the recommendations that have been proposed.

Selected "key" data needs issues facing the NIDR in implementing this agenda which aging-related statistics can help address follow. These issues most likely are similar to those of our sister agencies. Data are needed on:

- the oral health status of elderly in all subgroups, such as the frail, institutionalized, etc.
- the number and socio-economic and general health characteristics of the elderly in different subgroups, such as the frail, institutionalized, etc.
- the socio-economic characteristics of those elderly who use dental services and on those who do not. Also, how do the medical care seeking behaviors of these elderly compare to the dental utilization behaviors.

- the type of services received and frequency of dental visits by the elderly.
- the dental care expenditures, both out-of-pocket and third party, of those elderly utilizing dental services. How do these expenditures compare to those for medical care services.
- the type, number and distribution of dental manpower providing care to the elderly.
- the type, number and distribution of dental educators teaching geriatric dentistry.
- the type, number and distribution of dental clinical scientists and geriatric researchers capable of addressing the research agenda.

Views of the National Institute of Diabetes and Digestive and Kidney Diseases on Aging-Related Statistics

The responsibility of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) is to conduct and support research into the etiology, pathogenesis, treatment, cure, and prevention of a number of diseases that affect our Nation's elderly population. Many of the diseases under the purview of the NIDDK have the greatest prevalence and impact on the aged. These include Type II diabetes, chronic renal failure, end-stage renal disease, benign prostatic hypertrophy, cholelithiasis, diverticulosis, obesity, osteoporosis, etc.

These diseases and conditions do not convey extensive mortality as recorded in the United States vital statistics system. However, we are convinced that they do create excessive morbidity, disability, and health care costs, and place an undue psychologic and economic burden on the elderly. Documentation of these impact measures has been limited. In addition, our knowledge of risk factors for these diseases and our understanding of their natural history is inadequate making strategies for intervention or prevention difficult, if not impossible, to plan.

It is for these reasons that the NIDDK would be eager to collaborate with other agencies in a program to develop a full understanding of the nature, scope, and impact of these diseases on the elderly, and an understanding of the effect of life style, public policy and other factors on the incidence and prevalence of these diseases.

For example, our long term longitudinal study of the Pima Indians in Arizona has revealed a 50 percent increase in the incidence of Type II diabetes in that population over the last 10 years. This has resulted in an increasing incidence of end-stage renal disease in that population, and in addition to increasing the morbidity and mortality among the Pimas, this has created escalating health care delivery problems compounding preexisting problems.

What is not clear is the cause of this increased incidence in diabetes. Presumably the genetic predisposition to diabetes has not changed over the last decade, and the underlying causes must be sought in the environment, life style, socio-economic status or some other extraneous factor.

It is impressive that a metabolic and genetic disease like diabetes can be so sensitive to extraneous and "soft" factors such as life style, but this is very likely the case. Furthermore, this leads us to the conclusion that the more that is known about a given population, the more likely we will be able to identify those factors which govern the expression of latent chronic diseases. This is no less true for the growing aged population. Correlations between changes in the demographics and behaviors among the aged and the incidence and prevalence of disease will continue to be essential for the identification of populations that are at risk and the design of effective disease prevention strategies.

NIDDK

The policy implications of these considerations are many: e.g., an attempt should be made to design large population studies and census studies in parallel in order to build comparable data systems. Comparability could be based on common data elements especially in demographics. Attention should also be paid to the technology used to collect and store data with an effort to make data accessible. Census data should include relevant information about life style and other identifiable factors which have been implicated in the incidence and prevalence of disease.

The implementation of such policies would require a great deal of staff time and energy, but the result of even a modest effort would be to enhance our mutual understanding of available data. The NIDDK is ready to offer the relevant expertise in its disease areas in the design of future studies.

Pierre F. Renault, M.D.
Acting Director, NIDDK

NIMH

Summit Meeting on Aging Related Statistics
May 2, 1986
Issues for Discussion

Submitted by the National Institute of Mental Health

In this brief outline, the authors have emphasized data questions that should be of concern for future aged cohorts. For a preview, psychiatric disease diagnoses need to be included along with the medical diseases. In addition mental health services and drug prescribing need to be included along with the respective general medical services. Finally, costs of care–both direct and indirect, need to be assessed. Interagency collaboration on the gaps to be filled and analyses to be undertaken is an exciting opportunity. We look forward to the "next steps" and your responses on the below issues.

DIAGNOSTIC ISSUES

1. What will be psychiatric disease rates in future aged cohorts? Psychiatric disease can now be assessed using reliable measures based on the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Consideration should be given to quantifying the frequency of specific psychiatric diseases among the elderly. The recent Epidemiologic Catchment Area Surveys showed that psychiatric disease can now be assessed in the community and nursing home elderly. Future surveys can use the same instrument to measure psychiatric disease.

2. How many elderly will be suffering with both psychiatric and medical disease? Recognizing the potential impact of psychiatric disease on medical disease and physical on psychiatric, future efforts need to include both types of disease measures. Study designs need to be able to assess changes in disease status and include the risk factors associated with the development of the disease. In mental illness etiology, risk factors could include: the lack of social supports, multiple personal stresses and chronic medical illness.

3. What will be the extent of cognitive impairment? Studies assessing the elderly need to include the most sensitive cognitive impairment screening instrument. The older the age group, the more important to include such a screening instrument. The screen is not only useful for estimating the extent of cognitive impairment among the elderly, but also can be useful in determining where a proxy informant is necesssary. A related issue is to assess the ability of the general medical sector to diagnose dementia. Unless the present low rates of recognition are improved, the identificatiion of an effective treatment for senile dementia may be of little benefit.

NIMH

SERVICES ISSUES

1. What will be the extent of mental health services used by the elderly living in the community? What will be the extent of mental health services used by those in general medical settings? Future surveys should not only include the services, but if possible, be able to assess impacts of these services on health services and costs of care. Since primary care clinicians provide many of the mental health services delivered, comparisons of outcomes should be made for those services delivered by primary care and specialty mental health providers.

2. What will be the future costs of health and mental health services? In an era of cost containment and reduction it will be important to evaluate the economic benefit of specific treatment modalities. Not only should the direct costs of care be evaluated, but also the indirect costs and quality of care. A treatment that reduces direct costs but increases either indirect costs or quality of care needs to be further examined as to its actual value in reducing costs.

3. Who will be receiving psychotropic medications? These medications are frequently prescribed by primary care providers but frequently given without a mental health indication. Future surveys should include the drug dosage, regimen and length of time prescribed. In addition the survey should clarify the specialty of the drug prescriber.

4. What will be the extent of mental illness and mental services used in nursing homes? A very large gap exists in the lack of studies including reliable psychiatric disease measures; thus, an important step will be to reliably assess psychiatric disease in nursing homes populations. Then the use of mental health services needs to be determined. Eventually study designs should enable anlysing the impact of mental health services on mortality, future medical hospitalization and general medical costs.

5. What will be the elderly's future rates of use of public vs private mental health services? Given the increasing concern about the delivery of services in proprietary settings, it will be important to see if the elderly are receiving less, more or the same levels of services in both types of settings. Not only should the elderly's rates of admission and services received be assessed, but also the costs and quality of care.

SOCIAL SECURITY ADMINISTRATION

Issues for Summit Meeting

1. To what extent will older workers continue working a year or two longer after the turn of the century when the Social Security retirement age is raised to 66 and then to 67?

-- What will happen to the ability of older workers to continue working?

The increase in the retirement age was enacted largely to bring long-term costs in line with long-term income. It may have been hoped by some that active work lives will be extended by increasing longevity, in the future, thus making it easier for future retires to adapt to the higher retirement age. However, when SSA staff looked at recent trends in the health status of older workers as part of a Congressionally mandated study of the effects of raising the retirement age, they found that the recent improvements in life expectancy had not been translated into equivalent improvements in the work ability of older persons. We want to improve measures of health status as they relate to the ability to work. We are concerned about the extent to which the apparent lack of improvement in health status is real or whether, for example, it is the result of increased access to medical care making individuals more aware of health limitations. We also are very much interested in whether the apparent recent trends will continue in the future. Will continued improvements in medical care, the living and work environments, and healthier lifestyles translate into extension, on average, of active work lives?

-- What will happen to the willingness of the aged population to continue working?

1. Desire to stop, unlikely to decline.
2. Will financial ability to retire, improve or decline?

-- What is likely to be the future occupational mix; what proportion of the labor force will be in physically demanding jobs? What is the effect of the aging process on the ability to perform physically demanding jobs?

SSA's Retirement Age Study made some rough estimates of the future occupational mix and of the proportion of older workers likely to be in physically demanding jobs in the years 2000 and 2020. The long lead time before the change in the retirement age begins to become effective (in the year 2000) gives us a chance to refine those estimates, however. To fully understand the implications of the change in the retirement age, we also need to know more about the relationship between the aging process and the ability to perform physically demanding jobs. To what extent will working longer represent a hardship for those in physically demanding jobs? (e.g., how much more difficult is it the the average 65 or 67 year-old worker to regularly lift 25 pound weights or stand for extended periods of time than for the average 62 year-old worker?) Also, what will be the mental and emotional demands of future jobs?

-- To what extent may employers encourage older workers to continue working?

To some extent, current retirement patterns reflect current availability of large numbers of younger workers. But as the age structure of the work force changes in the future, to what extent may employers remove disincentives or offer incentives such as more flexible work arrangements to encourage their older and more experienced workers to stay in their jobs?

2. To what extent will retirees in the future rely on Social Security and to what extent on other income sources?

-- What will be the level of financial resources of new retirees in the future?

If the resources of the new retiree after the year 2000 were no greater than today's and if Social Security benefits were claimed at the same ages as the present, the change in the normal retirement age would result in a reduction in annual income of about 7 percent. But we need to know more about what tomorrow's resources will look like. For example, we know that today's new retirees enter retirement with greater assets than their parents. Will their children, also? To answer that question we need longitudinal data on the asset holdings of preretirement age cohorts. We need to know, for example, whether IRA's represent new savings or simply shifts in the form of investments being held. We also need to track trends in pension coverage and vesting. And how will pension systems react to the change in the retirement age? Will they fill the gap between the time workers quit working and the time they claim Social Security benefits? Or will they, too, increase the age at which pensions are payable?

-- What happens to the amounts and kinds of income of retirees as they age?

Cross-sectional data indicate that reliance on Social Security benefits is greater among older beneficiaries than among younger ones. However, we do not now have good data that show what happens to amounts and kinds of income for a given age group as it becomes older. Again, there are indications that new retirees are better off than their predecessors, but what will happen to their income sources as they age? Will their assets and pensions keep pace with inflation? To what extent will older persons spend their assets in order to maintain their income levels? Currently it appears that people continue to save even in retirement. SSA is planning to reinterview respondents in its New Beneficiary Survey (who first received Social Security benefits in 1980-81), and that survey will provide many of the answers being sought. Longitudinal data also will help to answer these questions.

3. Is it possible to develop definitions of such concepts as disabled, physically or mentally impaired, unable to work, and handicapped that would be used in common across the U.S. government as well as in the International community.

With the implementation of the higher retirement age for full Social Security benefits, we are concerned about older workers whose health status limits their ability to work but who are not sufficiently disabled to qualify for Social Security disability benefits. We also are concerned about the size of the population that is sufficiently disabled to meet the test of disability in our disability program and thus potentially eligible for it. Further, it would be most helpful to be able to make international comparisons about the proportion of the population in various countries that are potentially eligible for disability or invalidity pensions. Thus, it would be most helpful from our perspective if data gathering efforts such as the U.S. Census and the Health Interview Survey, for example, were to ask comparable questions about the extent and expected duration of disability and about whether health status limits or prevents a person from performing any job, his or her usual job, and/or housework, for example. To go a step further, it would then be helpful if we could develop standard nomenclature. At SSA, for example, we don't consider a person "disabled" unless he or she has a severe impairment that is expected to last at least a year and prevents the person from performing substantial work of any sort that exists in the economy.

VETERAN'S ADMINISTRATION

Aging-Related Statistics
Vital Issues: The VA Perspective

The following information areas have been identified by Veterans Administration officials as having significant potential for benefit from interagency cooperation in data collection:

1. Statistics on the functional status of the elderly population. Functional status measures (activities of daily living) need to be refined and broadened to more fully capture meaningful changes in elderly individuals' functional capability over time. In addition, standardization of measures across federal agencies would allow for meaningful comparisons of populations across programs, geographic regions, age groups, health and social service utilization patterns, etc. This information, particularly if incorporated into the census and made available by small geographic areas, would be enormously useful to health and social service planners.

2. Statistics on supply of services to the elderly. VA planners would find it useful to have a comprehensive inventory or database of institutional (including "board and care" homes) and non-institutional sources of community care for the elderly. This information is necessary for determining the current and projected fit between service availability and need. In addition, although the issue requires controlled experimentation, better information is needed on the substitutability of non-institutional community care for institutional care.

3. More and better longitudinal data on the elderly, particularly the population over age 85. This data could provide important epidemiological predictors of health risk, as well as disease and mortality incidence ratios. This information (a) would be useful in planning and targeting programs of prevention and service delivery, and (b) would help to answer the question of whether increases in the life span are accompanied by significant increases in the duration of chronic disease and disability.

HIGHLIGHTS

SUMMIT MEETING ON AGING RELATED STATISTICS

Stone House, NIH Campus
May 2, 1986

BACKGROUND

The United States is in the midst of a demographic transformation with the rapid aging of its population. Every aspect of American life will be affected. Because the implications are so pervasive, a meeting was co-sponsored by Dr. John G. Keane, Director of the Bureau of the Census and T. Franklin Williams, M.D., Director of the National Institute on Aging (NIA), for the directors of federal agencies concerned with aging-related statistics (participant list attached). Each agency prepared a statement of their views of the most vital statistical issues related to the older population.

PURPOSE OF MEETING

To determine how the statistical system can provide the data needed to answer policy questions for an aging society in a cost-efficient way.

STATEMENT OF STATISTICAL NEEDS BY AGENCIES

A. Substantive Issues: Nature of the Data Needed

1. Demographic and Epidemiological Data

   Major interest was expressed in establishing the relationship between health and socio-economic characteristics and in more accurate and complete information on caregivers, co-morbidity, competing risks, and multiple causes of death. For example, data on the functional status of the population needs to be developed and coordinated with social and economic data., also, data on the incidence and prevalence of disease and chronic illness need to be related to health, social, and economic risk factors as well as to economic consequences. Other issues include the characteristics of the oldest old, information on transitions over the life course, and improved population projections.

2. Utilization of Services

   Relationship between medical care, use of services, and socio-economic characteristics.

3. Economic Issues

   Socio-economic correlates of morbidity, disability, and mortality including the effect of health on employment, the level of financial resources available to the elderly, the allocation of public programs among generations, and the composition and distribution of health expenditures.

B. Process For Getting Needed Data

Many substantive issues require coordinated action among federal agencies and collaboration was often cited as the paramount need. Planning should be shared early. To avoid being bogged down by interest groups, the agencies need to agree to work to meet broad data interests and then individual agencies will work on their specific needs separately.

Collaboration at the conceptual state of data development would be the most beneficial. Examples include the development of health and socio-economic data systems; addressing the issues of data linkage and confidentiality, data quality (particularly for the cognitively impaired), standardization of definitions (e.g., disability), and detail of age tabulations where feasible; sharing of statistical techniques; more public use data tapes to allow users flexibility in tabulations; piggybacking of funding to add data to surveys to get more out of basic surveys; and working at the international level to enhance the comparability of data.

C. Staffing Needs

Need to increase training for epidemiologists, demographers, and biostatisticians for research on the older population.

DATA AVAILABLE NOW AND FUTURE PLANS

A. Social and Economic Data
(William Butz, Bureau of the Census)

1. Examples of Activities That Can Be Done by the Census Bureau, with Interagency Advice

   a. Present data more consistently
   b. Examine ways to increase the availability of information on the elderly from data already collected. This includes:
      (1) Publishing data on the elderly that has been collected but not disseminated such as more age detail, type of family unit, etc.)
      (2) Experiment with publishing survey data on the oldest old in ranges for given confidence levels where the sample size is too small to publish point data.
   c. The Census Bureau is testing a question on functional abilities for the 1990 census based on recommendations of an interagency committee.

2. Examples of Activities That Require Additional Resources

   a. Add questions to existing surveys
   b. Oversample for elderly in surveys
   c. Conduct new surveys on specific subgroups using the decennial census as a frame.

B. Health Data
(Dr. Manning Feinleib, M.D., Dr. P.H., National Center for Health Statistics)

Dr. Feinleib presented an overview of the NCHS national data system in terms of the health of the elderly. Death rates of the elderly have been declining since the early 1970's. The implications of this decline on morbidity and disability of the elderly is of particular importance in assessing the quality of life. He presented some examples of NCHS data relevant to policy concerning the elderly, and described several data systems which address changes over time in health status and their impact on the use of care. The followup of individuals tested in the 1971-75 National Health and Nutrition Examination Survey enables us to identify risk factors for disease as well as those factors contributing to independence. The 1985 National Nursing Home Survey collected data from family members on health prior to admission and after discharge. The 1986 Longitudinal Survey on Aging identifies changes in health. The proposed National Health Care Survey addresses quality of care issues. Dr. Feinleib concluded by noting the importance of:

1. enriching existing data systems by linking them to death records and administrative records;
2. conducting analyses that address particular policy issues;
3. disseminating data as public use files to allow maximum flexibility for analysis; and
4. promoting cooperation and collaboration among data collection agencies.

DECISIONS ON NEXT STEPS

An Interagency Forum on Aging-Related Statistics will be established to encourage cooperation among federal agencies in the development of data on the older population. The directors of federal agencies will appoint a senior staff person able to make broad policy decisions. Technical staff will work with the Forum and working committees will be organized to address specific issues. The Forum will be co-chaired by the Bureau of the Census and the National Center for Health Statistics (NCHS). The agency directors will stay closely involved with the Forum, acting as an oversight committee that will meet twice a year. The oversight committee will be jointly chaired by the directors of NIA, Census, and NCHS.

SUMMARY OF FEDERAL AGENCY STATEMENTS
SUBMITTED FOR
SUMMIT MEETING ON AGING-RELATED STATISTICS
MAY 2, 1986

(Summary by T. Franklin Williams, M.D., National Institute on Aging)

I. Substantive Issues: Nature of the Data Needed

A. Epidemiological and Demographic Issues

0 Changes in composition of elderly population (NIAMS, NCI, NCHSR, NHLBI, NIA)
0 Concomittant (multiple) medical conditions present at death (NCI)
0 Competing causes of death (NHLBI)
0 Accurate information on morbidity, disability and mortality for cardiovascular disease, chronic obstructive pulmonary disease (NHLBI), including case fatality rates
0 Accurate reporting of cause of death (NIAAA)
0 Risk factor levels, incidence, prevalence, severity, by gender, race, socioeconomic status, geographic variables (NHLBI, NIAAA, NIAMS)
0 Oral health status in relation to general health status (NIDR)
0 Numbers, health characteristics, guardianship status of older mentally retarded (NICHD)
0 Incidence and prevalence of eye diseases, including nursing home residents (NEI)
0 Incidence of complications associated with new therapies (NEI)
0 Differential effects of alcohol by age; incidence, risk factors, and prevalence of alcoholism by age; effect of living environment on health (NIAAA)
0 International comparisons of health conditions (NCI), of eligibility for disability/invalid pensions (SSA)
0 Trends in mortality, morbidity, active life expectancy (NCHS), longitudinal data, especially for over 85 (VA)
0 Overall functional data (VA); include functional data in census (AOA)
0 Nature, scope and impact of metabolic and renal diseases, in relation to life style and socioeconomic variables (NIDDK)
0 Overall demographic, physical, psychological, social and economic data (NCNR)
0 Information on caregivers (AOA)
0 "New demands" on medical care due to changing risk factors of multiple diseases (NCI)
0 Effects of declining heart disease mortality on population estimates for year 2000 (NCI)
0 Years of potential life lost and deaths by specific causes (NCI)
0 Interactive effect of drugs (NIAAA), drug usage (NIMH)
0 Affect on population projections of changes in mortality rates for specific diseases (NCI)

B. Utilization of services

- 0 Utilization of health systems by gender (NCI)
- 0 Utilization of dental services (NIDR)
- 0 Relations between medical care and dental services utilization (NIDR), including socioeconomic characteristics
- 0 Provision of care for older mentally retarded (NICHD)
- 0 Supply of services (VA)
- 0 Misplacement in programs because of misdiagnosis (NIAAA)
- 0 What is the level of psychiatric disease in nursing homes; how are services used; use of public vs. private services (NIMH)

C. Economic Issues

- 0 Cost of services to allow the "vulnerable" elderly to remain in the community (AOA)
- 0 Consumption patterns of elderly disaggregated by age (BLS)
- 0 Costs per patient for total cancer experience (NCI)
- 0 Expenditures (including sources of payment) for dental services (NIDR)
- 0 Economic consequences of chronic diseases (NCI)
- 0 Extent to which employers may encourage older workers to continue working (SSA)
- 0 Socioeconomic correlates of morbidity and decline in mortality (BCensus)
- 0 Effect of unemployment on health (BCensus)
- 0 Insurability of mentally retarded (NICHD)
- 0 How public programs allocate resources to children vs. older people (NICHD)
- 0 Work days lost, occupational changes, costs of custodial care, income tax losses, expenses for eye care for old people with blindness (NEI)
- 0 Employment of older persons; impact of change in retirement age for Social Security (SSA)
- 0 Future occupational mix, ability to perform demanding jobs (SSA)
- 0 Level of financial resources of future retirees, including asset holdings and tendency to spend to maintain income, by cohorts (SSA)
- 0 Composition and distribution of health expenditures, in relation to socioeconomic factors, geographic differences, etc. (NCHSR - National Medical Expenditure Survey)
- 0 Definition of retirement that reflects gradual transitions (BLS)
- 0 Financing of pension costs

D. Policy Issues

- 0 Data useful for policy on long term care -- retirement trends, housing costs, availability of family, living arrangements, women's roles, divorce, widowhood, advances in medical technology, economics of paying for care (BCensus)

II. Process for Getting Data Needed

0 More detailed information on age 75+ -- e.g., oversampling (NCI, VA, NIA, AOA, BCensus); requirement for 5-year breaks in all data (NIA); at least breaks for 65-74 and 75+ (BLS); oversample the physically disabled by age (NIAMS); vigorously pursue efforts to disaggregate data (AOA)

0 Report by gender for medical expenditures, hospital discharges, length of stay, chronic conditions (NCI)

0 Improve data quality, e.g., death certificates and hospital discharges (NCHS, NIA, AOA) and in institutions (BCensus)

0 Cohort information on mortality (NHLBI), income and how used (SSA), cohort trends for various information (NCHS)

0 Cooperative activities among federal agencies that will extend capabilities in cost-efficient ways (NIMH, BCensus, NCHS, NIA); interdisciplinary collaboration in design of surveys (NCHS)

0 Bridge between health and socioeconomic data (AOA, BCensus, IRS, NCI, NCHSR, NCNR, NHLBI, NIA, NICHD, NIDDR, NIDR, SSA)

0 Link survey responses to administrative data while protecting confidentiality (BCensus, IRS, NCHS, NIA)

0 Parallel statistics for children and older people re health status, socioeconomic status (NICHD)

0 Define scope and coverage of statistical data sets, specify nomenclature (NLM)

0 Cost data to permit analysis of clinical trials (NEI)

0 Determination of public expenditures for treatments whose efficacy has not been demonstrated (NEI)

0 Develop common definitions for disabled, physically/mentally impaired, handicapped (SSA), standardization of measures of function (VA)

0 Exclusion of institutionalized in surveys (NIAMS)

0 Include psychiatric diagnoses with medical (NIMH)

0 Quantify the frequency of specific psychiatric diseases among the elderly (NRMH)

0 Improve diagnosis of dementia (NIMH)

0 Determine transition parameters, e.g., probability of transition from independence to dependence (NCHS)

0 Develop longitudinal surveys (BCensus), including: subsequent to hospital discharge and to nursing home admission (NCHS), and of specific diseases (NIA); drinking patterns over the life course (NIAAA); on arthritis, musculoskeletal, and skin diseases for sub-groups (NIAMS)

0 Improved classification systems for health conditions (NCHS, NIAMS)

0 Methodological research on optimal procedures for eliciting information from and about older persons (NCHS, NIA)

0 Lower the barriers between federal agencies, scholarly institutions, industry and community agencies re sharing data -- public use tapes, etc. (NCHS)

- 0 Use piggyback funding to extend sample sizes of very old and to add factors to ongoing studies (NIA)
- 0 Address problem of delays in reporting by sharing personnel through fellowship and IPA positions (NIA)
- 0 Develop overall coordination through leadership by BCensus and NCHS (NIA)
- 0 Strengthen international data base in BCensus (NIA)
- 0 Design large population studies and census studies in parallel; comparable data systems (NIDDK)
- 0 Include data on life style in census (NIDDK)

III. Staffing Issues

- 0 Need to increase training of epidemiologists, biostatisticians for statistical research on the elderly (NIA)
- 0 Need for data on dental professionals, educators, researchers (NIDR)

Recommendations on 1990 Census

Prepared by
The Gerontological Society of America

The following recommendations on the 1990 census were developed by the Task Force on Data on Aging of The Gerontological Society of America and approved by the Society's Council.

The recommendations fall into one of two categories: questions to be asked, and material to be produced from the 1990 census.

I. Questions

A. Disability questions

1. Recommendations:

a. Eliminate the question on the use of public transportation as a measure of disability.

b. Add the following questions to determine number of disabled persons aged 16 and over:

i) **"Because of any impairment or health problem, do you need the help of other persons with personal care needs, such as eating, bathing, dressing, or getting around this home? Yes ( ) No ( )"**

ii) **"Because of any impairment or health problem, do you need the help of another person in handling routine needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes? Yes ( ) No ( )"**

2. Rationale

a. The use of public transportation is not a relevant measure of disability for large segments of the country where public transportation is not generally available (for example, large cities like Los Angeles and San Diego and rural areas). Further, it is not relevant for the institutionalized population.

b. A measure of disability is important for determining need and for planning services for the elderly at the local level (for example, by the Area Agencies on Aging). In contrast to the irrelevance of items on work disability for the elderly, the proposed questions would be relevant for the aged and for all non-working adults. These questions are part of the "core" of the yearly National Health Interview Survey. As such, they have been tested on a nationwide basis and would provide a link into the detailed health information from that survey. They are relevant for the institutional population and will provide valid comparisons to the non-institutional population. The question should be placed before the work disability item to avoid response problems which occurred in the 1980 Census. Because the work disability item was not relevant to the elderly, many persons incorrectly skipped over the items placed after it.

B. Informal Support of the Elderly Questions

1. Recommendation

Following question #20 ("If this person is a female, how many babies has she ever had, not counting still births?") ask:

a) **"(For both men and women age 65 and older) Do you have any living children? Include adopted and stepchildren. Yes ( ) No ( ) "**

b) **"For the child who lives nearest you, about how far in miles is it to his/her residence?**
_____ **1. Same household**
_____ **2. less than 1 mile**
_____ **3. 1-10 miles**
_____ **4. 11-50 miles**
_____ **5. 51-100 miles**
_____ **6. more than 100 miles**

2. Rationale

a. Because so much long-term care is provided by informal caregivers, primarily children, one consequence of reduced lengths-of-stay in hospitals will be more reliance on community-based care provided by families. However, there is currently no good measure of the proportion of the elderly that in fact have access to these informal caregivers. Knowing the dimension of need can help in planning local level service delivery. Are people geographically separate from their families, as "conventional wisdom" suggests? Are there regional differences in accessibility to family support that need to be taken into account? Where should institutional resources be targeted? These questions are designed to provide measures for these kinds of issues.

b. Further, access to informal caregivers is heavily dependent on geographical proximity. In the gerontological literature, questions about accessibility generally have been asked in terms of travel time to the closest relative. However, because there is increasing geographical dispersion and consequent dependence on such modes of transport as airplanes, travel time does not really capture proximity. Although mileage has a different meaning in, for example, New York City as compared to Wyoming, the proposed measurement would differentiate those within a community, those in the same general area, and those whose travel is a significant investment in time and/or money.

C. Income and retirement questions

1. Recommendation

Add to question #32, which asks respondent to identify the presence and amount of income from various sources (i.e., wages, Social Security, Rail Road Retirement, other, etc.) the categories of **"Private Pension Income"** and **"Government Employee Pension Income"**. (For "Government Employee Pension Income," the directions should say to include income from federal, military, and state and local public employee pensions but not to include veterans compensation or veterans pension income.)

2. Rationale

Question 32, as asked in the 1980 census, lumps private and public employee pension income under "other income." Providing specific information about the presence and magnitude of private and public employee pension income would serve four important functions. First, it would provide a measure of the amount of private and public employer pension income going to individuals and households, an important factor in assessing the economic well being of the the elderly. Second, to the extent that one wishes to define "retirement" as "receipt of retirement income," this information along with questions about age and the presence of income from Social Security, Railroad Retirement and Supplemental Security Income could be used to construct a "retirement" variable. The census does not ask if a person is retired. Third, this additional detail about income would increase the utility of the census data at state and local levels (i.e., administrators seeking to plan senior center activities relevant to the population served by the centers). And finally, the information would allow analysts to identify trends in income supplementing Social Security, an important issue in assessing the Social Security program.

D. In-kind benefits question

1. Recommendation

a. Collect information about the presence of publicly funded non-money income (food stamps, housing assistance) and employer-provided fringe benefits (pension contributions, private health insurance, etc.), but not about the value of these benefits.

b. Census should continue to use the current poverty index as an indicator of income adequacy, even if alternative poverty measures are developed as a result of collecting information on in-kind income.

2. Rationale

a. This issue was raised in response to Census Bureau's interest in knowing whether questions on non-money income and employer-provided fringe benefits ought to be included on the long form to enable the Bureau to develop small area data on these topics. If such information is to be collected, it is important to collect both types of information so that any new measures developed as a result of such information accurately reflect the presence of public and private in-kind benefits. We are concerned, however, about problems of placing values on these benefits and therefore recommend against attempting to collect information about the value of the benefits. Whether or not used to develop a new measure of economic well-being, information about the presence of non-money income could be of use to local welfare administrators and health care planners. Welfare administrators may want to know the geographic distribution of recipients of certain programs. Similarly, when planning services, local health planners may be interested in knowing the geographic distribution of persons with various types of medical benefits.

b. The poverty index is a useful though, of course, not flawless, indicator of income adequacy, which has become accepted by lay people. As such, regardless of any new measures developed, the Bureau should continue to use the index and distribute reports based on the index.

E. Board and Care Home Questions

1. Recommendations

a. A question identifying board and care homes should be added to the 1990 census.

b. The following question is offered as a suggestion, though we acknowledge additional development and pretesting is required: **"Is general supervision or personal care provided by this home to residents 18 years and older who are unrelated to person in column 1 and who require such care because of physical or mental condition, including infirmities associated with age?"**

The directions should state, **"'General supervision or personal care' includes responsibility for residents by owner or renter or other responsible adult in any of the following ways: ensuring personal safety, supervising personal hygiene and grooming, awareness of resident(s) whereabouts throught the day."**

2. Rationale

a. The Board and Care Home is a growing form of residential care facility for many aged and disabled persons. Federal, state and local governments have implemented policies of deinstitutionalization which have encouraged this form of living arrangement. No one knows with confidence how many homes or residents there are. Experts agree, however, that the number of persons in board and care facilities is expected to increase substantially during the next decade. Data are especially needed for planning and program development at the state and local levels of government and program administration.

b. Board and Care classification issues are currently being considered by two federally sponsored work groups: (1) Advisory Group for the Evaluation of the National Master Facility Inventory ; and (2) Ad Hoc Inter-agency Group on Board and Care Classification. The former group is revising a classification system of health institutions. The latter group is developing a set of criteria for a taxonomy item for sample surveys. The efforts of both groups indicate the difficulty of framing the question with sufficient preciseness. The Bureau should monitor the activities of and work with these groups in developing and testing the wording of a question which will secure accurate responses on this topic.

F. Race and Hispanic origin question

1. Recommendations

a. Continue to collect information on the 14 "racial" categories used in the 1980 census on a 100 percent basis.

b. Split the 1980 question on race into the following two questions:

i) "Is this person's race white, black, Asian or Pacific Islander, Native American, other (specify)."

ii) "Is this person Japanese, Chinese, Filipino, Korean, Vietnamese, Native American, Asian Indian, Hawaiian, Guamanian, Samoan, Eskimo, Aleut, or other?"

c. Retain the same 1980 question on Hispanic origin which includes four categories (Chicano, Cuban, Puerto Rican, and other Hispanic origins) and continue to ask it on a 100 percent basis.

2. Rationale

The 1980 Census included on a 100 percent basis one question on race (with 11 racial categories) and a question on Hispanic origin (with separate categories for persons of

Chicano, Cuban, Puerto Rican and other Hispanic origins.) The Census Bureau, without explaining, states that each of these items had reporting problems and suggested two alternative approaches for 1990, both of which would reduce the ability to disaggregate data by race and Hispanic origin.

The first approach would combine race and Hispanic origin into a single question (white, not Hispanic; black, not Hispanic; American Indian and Alaska Native; Asian and Pacific Islander; and Hispanic) that would be asked on a 100 percent basis, with an expanded version asked on a sample basis. The second approach would ask "simplified" (NOT DEFINED) race and Hispanic origin questions on a 100 percent basis, with expanded versions of the questions asked on a sample basis.

The Census Bureau has asked for comments on whether data were needed on the local level for 14 detailed "racial" groups and whether a response of a race group or of Spanish origin, but not both, would be acceptable.

a. One of the persistent criticisms of censuses prior to 1980 was that the information collected did not allow for disaggregation by race except in very large categories. The 1980 Census questions largely corrected for this, and they provided important baseline data for certain "minorities at risk", about which little information had been collected.

In terms of local needs, data on "at risk" populations are useful for planning services directed at particular ethnic groups. Even though the size of certain groups (e.g. Korean) may be relatively small, the availability of census data identifying these groups may be particularly important for communities with large concentrations of these groups. The same holds true when considering the aged population. For example, in planning for long-term care services at the community level, it is often important to know if older persons also are part of a particular ethnic group. By itself, the fact that the United States is a multi-racial and multi-ethnic society provides strong rationale for continuing data collection on a 100 percent basis which provides a basis for documenting this diversity.

b. We are recommending that the 1980 "race" question be split because the categories used in the 1980 question are not mutually exclusive (e.g., the 1980 question could be confusing to a white Hawaiian who could properly check two categories).

c. Similarly, considerable diversity of circumstances, culture and needs exists within the broad classification of Hispanic. Also, "Hispanic" groups are generally considered "minorities at risk." The 1980 Hispanic origin questions provided greater opportunity to identify this diversity (and its implications) on national, state and local levels. For reasons cited above, the census should continue to collect information on a 100 percent basis which allows for disaggregation among four categories of Hispanics.

G. Populations in health care institutions questions

1. Recommendations

a. From a sample of the population in health care institutions, collect information on place of birth, ancestry, years of school completed, marital history, veteran status, disability, access to informal supports, and on retirement and income. (See prior recommendations on last three items.)

b. Replace question on residence five years ago with, **"When was the last time you lived outside a health care institution? _____ Years _____Months"**

c. Do not question this sample about current language, school enrollment, major activity five years ago, citizenship and year immigrated, employment/unemployment, place and journey to work, occupations, hours worked, or looking for work.

2. Rationale

In making these recommendations, the Society understands that the Census is reviewing inclusion of this set of questions based on the validity of the responses. The Society is not in a position to comment on that issue. However, the Bureau is urged to consider our recommendations in relation to the validity of the items.

a. Given the growing importance of the health care institution as a local, state, and federal planning and budget issue, it is important to collect information on who is living in health care institutions and why. The questions would provide baseline data to permit comparisons on the same items with non-institutionalized elderly, which in turn would allow examination of factors affecting current institutionalization and development of projected future use patterns.

b. Along with knowing who and why about the health care institution population, it is important to know how long people have been in such institutions, particularly in seeking to determine demand for such facilities and/or impact of efforts to delay or shorten periods of institutionalization.

c. The items recommended for exclusion from this sample are not relevant to the aged who constitute the majority of persons in health institutions.

II. Recommendations relating to products of the 1990 census

A. Providing block data

1. Recommendations

a. The Census Bureau implement its plan to process and make available 100 percent data by block for the entire nation.

b. The Census Bureau make available computer-generated block maps and provide low-cost tabulations for subgroups as requested and defined by users of the information.

1. Rationale

a. In many ways, local areas are the ideal planning units for aging programs. Planning at this level is now mandated by the Older Americans Act and will become even more important as communities and even neighborhoods compete for block grant funds awarded to the states. Since the size of one's "social world" tends to contract with diminished competency, planning at the local level also makes "theoretical" sense. Only at this level can those charged with planning and program development take into account variations in the social, physical, and service aspects of the environment. Local-area data facilitate not only a range of planning decisions (e.g., locating service centers in areas with large concentrations of elderly) but also aid in research (e.g., constructing sampling frames).

In spite of the obvious advantages of local area planning, such efforts have been hindered in the past by the lack of readily-available data at the smallest possible level of aggregation. Although data from the 1980 Census was available at the block level, item coverage was very limited. More detail is available on computer tapes for larger units (e.g., pre-determined Block Groups and Census tracts) but the boundaries of such units do not necessarily coincide with service delivery areas, neighborhoods, or small area administrative units. The Bureau is considering making the more detailed information available on computer tapes for individual blocks and not for larger units. Users could combine blocks to get figures on large units.

b. The availability of block maps and low-cost tabulations obviously would be useful for program planners and administrators at the local level. It would be particularly useful if tabulations on high-risk subgroups (i.e., women over 75, blacks in poverty) on a block basis were available in response to specific requests from users of the information (program planners, administrators, researchers).

B. Providing age-detail in published reports

1. Recommendation

All published tabulations distinguish those 65-74 from those 75 and older. When suppression of detail is not necessary, as for example in tabulations pertaining to tracts or larger units, break out data on those 85 and over. Provide five year age groups, up to and including 85, whenever possible.

2. Rationale

One of the fundamental truths of the demography of old-age is that the older population is far from a homogeneous group. At any point in time, for example, the older population includes at least two different generations. To take into account these generational differences as well as age-related changes in functional capacity, income security and living conditions, detailed age-breaks are essential. Age is, of course, pre-coded in published reports but even on the summary tape files most tabulations pertain simply to the 65 and over population. User-definitions are an advantage of the micro data files, but these files lack the geographic detail needed for many planning purposes.

C. Providing retirement-related tabulations

1. Recommendation

The Census Bureau, using "hours worked" and "labor force status" data, construct a variable which, with certain assumptions, would make possible disaggregation of the older population into "fully retired", "partially retired," and "not retired" categories, and that the Bureau cross-tabulate the resulting "new" variable with appropriate other variables, such as income, source of income, geographic location, etc.

2. Rationale

As noted in the rationale for the recommendation dealing with income and retirement questions, the census does not include any specific question on retirement status.

Since "amount of labor force activity" is one way of defining retirement status, the proposed variable could be created from information already collected by the census. The variable could be used to generate additional information about employment among the older population, increasing the utility of census data to state and local planners and program administrators. For example, such information would be useful in designing employment programs. Also, this type of information will be important in determining impacts of changes in Social Security laws designed to encourage increased work effort. The changes will become effective in the 1990s and early 2000s.

AVAILABILITY OF FEDERAL DATA
ON THE AGED:
RECENT CHANGES AND FUTURE CONCERNS

A Report of

The Gerontological Society of America

By

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June 3, 1986

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FOREWORD

While statistics are rarely considered one of the more exciting areas of government policy, they are the underpinning for many private and public sector policies and programs. Statistics are used to determine congressional representation and cost-of-living increases in the private and public sectors, influence trade policies, identify emerging policies and changes in existing conditions, and to allocate federal resources for health, education, welfare, and economic development.

Over the next five decades, this nation will witness an unprecedented change in the age structure of its population. By the year 2030, it is projected that 65 million people or 22 percent of the population will be over the age of 65, as compared to 29 million or 11 percent today. To meet this challenge, decision makers will need sound information about these demographic changes if they are to make effective, efficient policy choices. Most importantly, policy makers must have the necessary data to identify current and projected differences among the elderly: how do those between the ages of 65 and 75 differ from those who are older than 75 or those over 85?

Maintaining the solvency of Social Security and containing health care costs are examples of major policy decisions requiring sound data. Determining and ensuring the solvency of the Social Security system depend on accurate tracking of current and future population and income trends. Health care cost containment policies rely on accurate monitoring of current health status and expenditures; of medical treatment to learn what is working and what is not; and of the long-term health of the population to learn effects of such innovations as prospective payments to hospitals and health promotion programs.

Recognizing the critical role federal data will play in preparing for an aging society, the Gerontological Society in 1984 adopted federal statistics as an ongoing issue of concern and established a permanent task force to focus on this issue. Specifically, the task force has been concerned about how past and future reductions in federal data collection programs have affected and will continue to affect the ability to make sound public policy and whether these reductions in the long and/or short run will actually result in increased costs. For example, the Gramm-Rudman-Hollings budget cuts of 4.3 percent for 1986 mean that already-planned efforts to reduce the error in estimating the Consumer Price Index (CPI) may be deferred. While this sounds like a rather mundane issue, according to the Bureau of Labor Statistics each one percent increase in the CPI increases the federal budget deficit by $4.6 billion, affecting indexed tax brackets, military and civil service pensions, and Social Security cost-of-living adjustments. In addition, millions of workers' union contracts, pension agreements, many private contractual agreements, and divorce settlements are indexed to the CPI. Errors in the CPI will have a very large effect on the economy and federal and family budgets. Similarly, defense procurements are often indexed to the Producer Price Index, which is becoming less accurate with time.

The Society's Task Force on Data on Aging has looked closely at the effects of budget cuts on the collection of aging-related data by the federal government over the past several years. This report is a reflection of this ongoing involvement. In December of 1984, the Task Force commissioned a paper, prepared by James Storey of Chambers Associates, that described the effect of budget reductions of the early 1980s on the collection of data on the elderly (a summary of the report is included in the appendices). This report updates the 1984 paper. Together the reports provide a baseline for assessing the future directions of federal data collection programs.

The Society's reports also document the significant reductions in policy research and analysis capabilities that have already occurred and the major impact these reductions have had on information previously available to lawmakers and policy makers. Continuing such reductions will have serious, tangible effects on the income, health, and well-being of all Americans young and old.

"A Guide to Federal Responsibility for Data Sources on Aging," prepared by the U.S. Senate Special Committee on Aging, has been included as an appendix to this report. The Guide identifies key federal data sources on the elderly and the congressional committee with responsibility for the programs.

The Gerontological Society of America
June, 1986

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I. SUMMARY

A report issued by the Gerontological Society of America one year ago documented the losses in federal data on the aged during the 1980s. These losses occurred partly due to budget cuts, but a reorientation of federal research away from policy issues and toward administrative issues was also a prime factor.

In the past year, there were fewer cutbacks and an occasional sign of lost ground being regained, although progress in reversing the earlier trends was far from complete and did not affect all agencies. Further deterioration in research resources has continued in some cases.

All in all, 1985 was not a good year for data collection activities but was not as bad as the preceding four years. However, the advent of the Gramm-Rudman-Hollings (GRH) balanced budget legislation threatens to renew the downward slide for these agencies, with the ultimate consequences held forth by that law being so repugnant that it is almost certain that Congress will act to avert the across-the-board spending cuts at some point in the process. The President's 1987 budget, which would normally be viewed with disfavor by supporters of an adequate data collection effort, is actually preferable to the specter of the cuts predicted under GRH for 1987.

The year 1985 was characterized by a maintenance of an inadequate status quo in most statistical programs. Only one agency collecting data on the aged, the National Center for Health Statistics, actually saw a decline from 1984 in its inflation-adjusted funding level. The agency with perhaps the greatest problems, Social Security's Office of Research, Statistics, and International Policy, saw a number of improvements, most notably an OMB approval to field-test a long-delayed survey of SSI eligibles, but such improvements are now threatened by the GRH budget cuts.

Indeed, 1985 appears to have been the proverbial calm before the storm. The GRH process of across-the-board budget cuts is already inflicting a 4.3-percent cut on the 1986 budgets of all the research and statistics agencies, a cut similar in size to those in the early 1980's. One immediate effect of this cut was a 50-percent reduction in the sample size for the National Health Interview Survey. Another effect was the deletion of funds for extramural pension research at the Department of Labor.

Looking ahead to 1987, the GRH formula will call for across-the-board cuts of as much as 20 percent for non-defense discretionary spending compared to the pre-GRH baseline projected for 1987. Reductions of that magnitude would deal data collection efforts a severe blow, probably resulting in cancellations and delays in new activities, further cuts in survey sample sizes, stretchouts in survey frequency, fewer professional staff, and less extramural research. The capability of public and private organizations to monitor the health and welfare of the aged would be seriously impaired.

As the 1986 cuts take hold, Congressional oversight regarding the effects on data collection and generation will be important. The impact of announced cuts needs to be traced to the consequences for the aged. Congress should be wary that pressures to reprogram the cuts over time may lead to unanticipated effects on vulnerable population groups.

The President's 1987 budget would impose severe funding cuts on several of the research and statistical programs reviewed in this report: Administration on Aging research, Department of Health and Human Services Policy Research, the National Institute on Aging, and Health Care Facilities Administration research and evaluations. However, despite the severity of the budgets for these programs, the President's budget overall would treat research and statistics more favorably than would the 1987 round of GRH budget cuts.

In summary, programs important to collection of data on the aged will experience significant cuts in 1986 due to Gramm-Rudman-Hollings after a relatively benign year of 1985. These cuts will renew the menace to a viable data base on the aged that earlier budget cuts had threatened. Preservation of adequate data collection efforts beyond 1986 must rely on Congress imposing its own priorities in place of the across-the-board budget cuts of discretionary spending required by the GRH process. However, there is certainly no guarantee that Congress will reach agreement on an alternative to GRH in time to be in place as FY 1987 begins next October. Even with such an agreement, Congress is committed to a major reduction of the budget deficit, so budgets for statistical agencies will be very tight even without GRH.

Should Congress fail to enact its own budget priorities, the GRH process will lead to changes in the federal budget that will prove to be untenable. By 1991, non-defense discretionary spending would be held to 55 percent of the real value of pre-GRH 1986 funding levels. At such levels, many data collection efforts would have to be completely abandoned. To apply funding cuts of this magnitude across the board throughout the federal government would seem to be politically impossible.

II. INTRODUCTION

In February 1985, The Gerontological Society of America published a report entitled "Recent Changes in the Availability of Federal Data on the Aged". The purposes of this new report are twofold: (1) to update the 1985 study's findings; and (2) to consider the implications of the President's 1987 budget proposals and the new Gramm-Rudman-Hollings balanced budget legislation.

The report first addresses developments in 1985 that affected the collection and generation of data on the aged by the federal government (Section III). The effects of Gramm-Rudman-Hollings on 1986 funding are then discussed (Section IV). Next, the 1987 budget outlook is reviewed (Section V). Finally, the longer-run situation under Gramm-Rudman-Hollings is considered (Section VI).

III. DEVELOPMENTS IN 1985

Overall, 1985 was a year in which there was relatively little change from the prior year. Budget levels after adjustment for inflation remained fairly stable compared to the prior year. Progress was made in some agencies in improving the situation that existed previously, although not to a degree sufficient to restore the ground lost in the early 1980s. The deterioration in staff resources experienced earlier worsened in several agencies.

This section first reports on agency budgets for 1985 and then discusses major data collection developments by data category.

A. Budget Trends

The Congressional Research Service has estimated funding in both nominal and constant dollars for statistical agencies for fiscal years 1978 through 1985. Selected information is shown in Table 1.

Funding levels were significantly higher in 1985 than in 1984 for the Census Bureau and the Bureau of Labor Statistics (BLS). Only one of the agencies shown in Table 1, the National Center for Health Statistics (NCHS), experienced a funding decline. The research and statistics offices of the Social Security Administration (SSA), the Department of Health and Human Services (DHHS) and the Department of Housing and Urban Development (DHUD) received funding for 1985 that was at or slightly above 1984 levels.

Adjustment of these trends for inflation indicates a more negative situation for these statistical programs. NCHS funding fell by 11 percent in constant dollars, reaching a level equal to two thirds of the 1978 level. Although the inflation-adjusted figure for BLS was up by 4 percent from 1984, that represents only a return to the previous peak funding levels of 1979-1980. The constant-dollar figure for the Census Bureau's ongoing programs exceeded comparable data for all prior years, due mainly to the new Survey of Income and Program Participation. The other agencies held their own in real dollars from 1984 to 1985 but at levels significantly below their peak funding of prior years.

A general conclusion from these budget trends is that the two largest agencies responsible for data collection (i.e., BLS and Census) fared better in 1985 relative to the treatment of the others.

B. Significant Data Developments

Last year's report of the Gerontological Society detailed numerous effects of the budget cuts and priority shifts that

TABLE 1. Federal Budget Authority (BA) for Selected Research and Statistics Activities, 1978-1985
($millions)

BA in current dollars:	1978	1979	1980	1981	1982	1983	1984	1985
Census Bureau, ongoing programs (excl. transferred activities)	48	51	54	57	57	67	75	83
Census Bureau, censuses	83	202	666	178	88	99	78	81
BLS (excl. transferred activities and CPI revisions)	84	95	103	111	113	122	128	138
NCHS	38	39	43	38	38	41	46	43
SSA/ORSIP	NA	NA	NA	26	18	17	25	25
DHHS/ASPE	NA	NA	7	9	16	19	15	16
DHUD/PD&R	NA	NA	9	15	14	14	10	11
BA in 1980 dollars:								
Census Bureau, ongoing programs (excl. transferred activities)	55	55	54	50	47	53	58	61
Census Bureau, censuses	95	218	666	156	73	78	60	60
BLS (excl. transferred activities and CPI revisions)	96	102	103	96	93	96	98	102
NCHS	44	42	43	33	31	32	35	31
SSA/ORSIP	NA	NA	NA	22	15	13	19	18
DHHS/ASPE	NA	NA	7	8	13	15	12	12
DHUD/PD&R	NA	NA	9	13	11	11	8	8

Source: Congressional Research Service

occurred between 1980 and 1984. This section comments on related developments since 1984 within five data categories: general population data, income and wealth data, health data, labor force data, and data on housing and living arrangements.

1. General Population Data

Delays in processing and publishing the 1980 decennial census were reported last year. That effort was finally completed during 1985. Slowdowns in reporting other Census data continue to be a problem, however.

The Survey of Income and Program Participation (SIPP) continued to be implemented, and it has emerged as a major new data source for a wide variety of research. Although limited in its utility to the field of aging because of the sample size, it does provide additional data on the elderly that would not otherwise be available had SIPP been terminated as planned in 1982. However, the tight budgetary situation prevents SIPP improvements that are needed to realize the original intent that SIPP be used extensively in studies of the aged.

Attention at Census will now turn increasingly to planning for the 1990 census. This planning effort will be affected by the across-the-board budget cuts required by the Gramm-Rudman-Hollings (GRH) law.

2. Income and Wealth Data

Loss of experienced staff continued to affect the federal capability in this area. There has been almost a complete exodus of the senior Income Security staff from the Office of the DHHS Assistant Secretary for Planning and Evaluation (ASPE). The orientation of the new Secretary and his early appointments suggests that the health area will receive the lion's share of top-level attention. Thus, the chance for a turnaround in the dwindling Income Security staff resources under the new Secretary does not look good.

In the Social Security Administration, the reorganized Office of Research, Statistics and International Policy (ORSIP) regained a part of the staff that had been transferred to the Office of Supplemental Security Income. However, the 40 research and statistics staff that once were available for studies of Retirement and Survivors Insurance have now attrited to 8 in number and continue to work on program management studies. It is expected that some downgrading of this staff will occur due to its reduced size and altered assignments.

ORSIP has improved its rate of data release and research publication since one year ago. The agency has also won a major battle with OMB by obtaining approval to pretest the Supplemental Security Income (SSI) Survey that was held up for several years. Full implementation could yet be disrupted by the GRH budget cuts, however.

Some analysis related to disability is now underway at ORSIP; this activity had ceased when reorganization sent the former disability research staff to the Office of Disability Insurance. A Congressionally mandated study of the effects of raising the normal retirement age has been allocated the necessary resources for a timely completion.

ORSIP's extramural research funding continues to be quite limited, although a few grants were made during 1985.

The Administration on Aging (AoA) has terminated its Income Maintenance Policy Research Center as well as the five corresponding centers in other policy areas. AoA's research grant program remains at a low funding level, but there is more emphasis being given to policy research than was the case a year ago.

The pension research staff at the Department of Labor (DoL) has remained at a constant level over the past year and has attained a greater degree of visibility as part of a new Pension and Welfare Benefits Administration. The staff's focus has been concentrated on two key political issues: health benefits for pensioners, and the reversion of "excess" pension fund assets to corporate sponsors. DoL's pension staff continues to have problems funding extramural research, having lost its funding request for 1986.

DoL's Office of the Assistant Secretary for Policy (ASP) has continued to lose professional staff and has no pension-related work underway in-house. However, ASP has funded two extramural studies of the relationship between pension rules and job-choice decisions.

3. Health Data

The surveys of the National Center for Health Statistics (NCHS) were reduced in frequency in the early 1980's to meet the budget reductions of those years. The situation stabilized in 1985, with no further stretchouts occurring.

The National Health Interview Survey sample size, which had been the target of cost saving, was maintained at its 1984 level for 1985. However, the sample will be cut in half for 1986 in order to meet the sequestration required of NCHS by Gramm-Rudman-Hollings.

The reinterview of the sample of the National Long-Term Care Survey was completed by the Health Care Financing Administration (HCFA) in 1985 as planned.

4. Labor Force Data

No new cutbacks occurred during 1985. The sample size for the Consumer Price Index survey was to be reduced in 1986 to comply with the GRH budget cuts. The result would have been less accurate measurement for an index that is used extensively in aged benefit computations and in research on the aged. However, due to opposition to this cut, BLS is reprogramming funds to protect the CPI sampling. Thus, the cut will show up in other BLS activities.

The reductions in the Current Population Survey (CPS) sample size that were made several years ago are now being felt by researchers, who are limited in the size of population group that can be studied from current CPS data compared to the prior CPS data bases.

5. Data on Housing and Living Arrangements

DHUD continues to organize its policy studies around topics that have no specific age focus. The American Housing Survey, which was stretched out from an annual to a biennial basis, remained unchanged during 1985.

IV. THE IMPACT OF GRAMM-RUDMAN-HOLLINGS IN 1986

Across-the-board budget reductions for FY 1986 took effect under the new Gramm-Rudman-Hollings law as of March 1, 1986. A federal court has found the law to be unconstitutional in its procedure for automatic cuts that occur without Congressional action, but the law will stay in force until the U.S. Supreme Court hears an appeal later this year. If the Supreme Court agrees with the lower court, the law will operate as enacted except for one change: Congress will have to order the across-the-board cuts instead of the Comptroller General.

The reduction procedure calls for cuts of 4.3 percent in 1986 budget authority in all domestic programs not accorded special treatment under GRH. Because the cuts must be achieved during the last 7 months of the fiscal year, the effect of this cut in many cases will be to reduce spending by 7.4 percent in order to obtain a 4.3 percent cut over the whole year.

All statistical and research activities concerning the aged will be affected by these cuts in some way. The degree and nature of the cuts will vary among agencies because the unit of budgetary control within which a particular statistical office is contained varies and because, within the "program, project and activity" (PPA) to which sequestration applies, the federal manager has discretion on how to achieve the necessary cutback. Within a PPA, cuts may well exceed 4.3 percent for statistical offices should the manager's review lead to a low priority for those activities.

Six of the activities covered in this review are organized as appropriation accounts in the budget. The cuts by account that are required in 1986 were specified by GAO in the sequestration order: (1) Census Bureau Salaries and Expenses, $4.4 million; (2) Census Bureau Periodic Censuses and Programs, $4.5 million; (3) BLS Salaries and Expenses, $6.8 million; (4) DHHS Policy Research, $0.3 million; (5) DHUD Policy Development and Research, $0.7 million; and (6) National Institute on Aging (NIA), $6.7 million.

Two of the aged data and research activities are specific line items within accounts and, thus, will also be directly subject to sequestration. These line items and the amounts to be sequestered are: (1) NCHS, $1.4 million; and (2) HCFA Research, Development and Evaluation, $0.1 million. These amounts are estimates since no official sequestration figures have been published by line item at this writing.

The remaining research and statistical activities pertinent to the aged are neither accounts nor line items. These activities may or may not be subject to the 4.3-percent cut depending on the specification of PPA's for their agencies. Those that are not PPA's could be cut more than 4.3 percent if they are regarded as lower priorities than the non-statistical activities with which they are grouped. These activities are: Social Security/ORSIP; DoL/ASP; DoL Pension and Welfare Benefits research; HCFA administrative data collection; VA research and statistics; AoA research; and Food and Nutrition Service research.

The likely substantive results of these sequestrations are currently the subject of much speculation but few hard facts. It seems probable that the following are going to occur in varied combinations across the research and statistical programs:

- Planned new activities will be delayed or terminated. Social Security's new SSI Survey may experience further delay, for example.
- Vacant staff positions will not be filled, denying agencies the opportunity to recover expertise lost in earlier cutbacks.
- Staff will be furloughed or permanently reduced, which will slow down the processing and publishing of new data and make public use of federal data systems even more difficult than it already is.
- Extramural research will be reduced, thereby intensifying the sharp decline in academic research on the aged.
- Survey sample sizes will be cut, making surveys less useful for studies of subgroups like the aged.
- Survey frequencies will be reduced, resulting in longer gaps between actual socioeconomic change and policy responses.
- Publications will be reduced, thereby decreasing the number of people who can access federal data.

Given the size of the 1986 cuts, these impacts will be similar in magnitude to the budget cuts of 1981 and 1982 in some agencies. The cumulative effect will be to weaken the capability of both public and private officials to monitor the health and welfare of the aged and to lessen the responsiveness of public policy to emerging problems.

The cuts to be made are not set in concrete in many cases but may be altered as priorities change or political pressures build. Thus, an area that appears relatively safe in 1986 could yet sustain a reduction should other planned cutbacks be altered. While the specific effects are unclear, the problems listed above constitute a set of criteria that Congress can use to evaluate the problems the GRH process may be causing for data availability.

V. THE 1987 BUDGET OUTLOOK

If the GRH across-the-board budget cuts should take effect for FY 1987, it is estimated that a cut of 20 to 25 percent would be required in budget authority for non-defense discretionary programs compared to what funding would be if 1986 appropriations were simply adjusted for inflation. The President has proposed a budget that will accomplish the GRH deficit reduction goal based on spending changes that would support his own priorities. This section first reviews the President's proposals and then looks at the cuts required by GRH if an alternative budget is not adopted by Congress. While Congress will probably not accept the President's proposals and may well succeed in averting the GRH automatic cuts, Congressional fiscal policy will certainly strive to achieve the same degree of deficit reduction called for in the GRH law.

A. The President's 1987 Budget

Budget requests for the accounts and line items most pertinent to aged data collection and generation are summarized in Table 2. It should be noted that budget increases or decreases do not specifically indicate impacts on aged data since many of the programs involved conduct a broader range of activities than collection of data on the aged.

As Table 2 shows, the funding requested for 1987 exceeds the 1986 post-GRH base for most programs. The exceptions are: NIA ($1.3 million less in 1987); HCFA research ($10.8 million less, a 37-percent reduction); AoA research ($11.4 million less, a 48-percent cut); and DHHS policy research ($1.0 million less, a cut of one-sixth).

In some cases, the 1987 funding increase requested would simply offset the GRH cut of 1986 and restore the 1986 enacted funding. This situation describes the requests for Social Security's administrative budget and for BLS Salaries and Expenses. In the case of the Census Bureau's Salaries and Expenses account, there is an increase for 1987 over the pre-GRH 1986 base, but it is too little to cover the expected loss in value due to inflation.

The 1987 request for NCHS is $3.4 million (7 percent) above the pre-GRH 1986 base. If enacted, it would provide that agency with a real gain of 3 percent after inflation. The large 1987 increase for the Census Bureau's Periodic Censuses and Programs account is due mainly to the buildup for the next decennial census.

B. The 1987 Budget Under Gramm-Rudman-Hollings

While the President's 1987 budget is rather tight for most of the programs reviewed in this report, his budget would compel

TABLE 2. The President's 1987 Budget Request for Selected Statistical Programs

Agency/Account (or line item)	Budget Authority ($ millions)			
	1985 actual	1986 enacted	1986 with GRH cuts[a]	1987 request
AOA/Research and Training	24.7*	25.0*	12.5*	12.5*
BLS/Salaries and Expenses	152.9	158.6	151.8	159.4
Census Bureau/Periodic Censuses and Programs	81.0	105.6	101.1	185.6
Census Bureau/Salaries & Expenses	85.3	90.4	86.5	91.7
DHHS/NCHS	42.7*	46.6*	44.6*	50.0*
DHHS/Policy Research	9.8	6.5	6.0	5.0
DHUD/Policy Development & Research	16.9	16.9	16.2	18.9
DoL/Pension and Welfare Benefits Program	30.2*	28.9*	27.7*	33.6*
FNS/Food Stamp Administration	48.2*	46.9*	44.9*	49.2*
HCFA/Research, Demonstrations & Evaluations	34.6*	30.6*	29.3*	18.5*
NIH/NIA	144.5	156.5	147.1	145.8
SSA/Administration	3,232.1*	3,608.7*	3,522.3*	3,608.8*

a In some cases, 1986 rescissions have been requested and are included in these figures. For AoA Research and Training, the rescission amounts to $11.4 million.

* This program is a line item within an account; thus, data are in obligations rather than budget authority.

Source: The President's Budget for 1987.

severe reductions in only a few cases (the research programs of AoA, DHHS/ASPE, and HCFA). It appears that Congress will not adopt this budget; thus, Congress must reach agreement on a budget of its own that meets the GRH deficit target to avoid the next round of across-the-board cuts. If no agreement is reached by October 1, 1986, the cuts mandated by GRH will presumably take effect. With a few exceptions, these across-the-board cuts will be much more damaging to aged data collection and research than would the budget proposals of the President.

The 1986 Annual Report of the Congressional Budget Office projects a GRH cut of 8.4 percent for non-defense programs in 1987, but that estimated cut would be from the 1986 post-sequestration funding levels. The projected GRH cut would be 16.7 percent from the pre-GRH 1986 baseline adjusted for inflation. Furthermore, the CBO estimate presumes that defense funding will not be increased at all in the 1987 appropriations process, which is widely regarded as an unrealistic basis for the estimate. Assuming some reasonable defense increase puts the 1987 GRH non-defense cut at or above 20 percent from the pre-GRH current services baseline.

It is pure speculation at this early date to judge the likely effects on aged data collection of a 20-percent cut, but all programs would no doubt be hurt severely. The statistical and research programs that coincide with accounts or line items in the budget structure would suffer the full 20-percent cut, although the enacted base from which the cut would be made could include funding increases should Congress enact such increases prior to October 1. For other statistical programs, the size of the GRH cut cannot be predicted since they are included in the same line items with other types of programs. However, it is safe to assume that all would face major reductions in budget authority.

A cut on the order of 20 percent in the funding of a statistical program would probably lead to the complete elimination of some data collections. Sample sizes for the surveys that survived might be reduced to levels that would render them useless for most applications in the field of aging. Research programs would lose even more of their dwindling resources for extramural grants and contracts. In the face of such tight budget constraints, pressures could intensify in some agencies to move away from any focus on a specific population subgroup such as the aged.

VI. THE OUT-YEARS UNDER GRAMM-RUDMAN-HOLLINGS

Looking beyond 1987, it is apparent that Congress must either modify the GRH procedure or enact alternative deficit reduction measures. If the GRH process plays out through 1991 as currently legislated, it would mean the elimination of half of non-defense discretionary spending compared to the pre-GRH current services baseline.

This conclusion flows from estimates of the magnitude of cuts required to meet the GRH deficit targets each year. An analysis released by the House Select Committee on Aging predicts the cuts in non-defense discretionary spending under GRH each year. The implications of these estimates are summarized in Table 3.

The GRH reductions are calculated from a current services baseline that increases 1986 enacted levels by inflation each year. As Table 3 shows, if the enacted base were kept whole with respect to inflation, 1991 funding would be only 55 percent of the projected current services level for 1991. That level of funding would be equal to 64 percent of the actual 1986 enacted level. Thus, non-defense discretionary funding in 1991 would amount to slightly less that two-thirds of the 1986 level prior to any GRH cuts and a little more than half of the real value of that 1986 level.

It is reasonable to assume that Congress will not be content to oversee a government that consists of the Social Security and Medicare systems, income transfers to the needy, a greatly weakened military and about half of what now constitutes other federal activities. Either additional revenues must be raised to reduce the deficit, or the GRH procedure must be drastically modified to avoid politically unthinkable outcomes. When will the necessary compromise with reality occur? That is the crucial question for those concerned with preserving an adequate statistical resource on the aged.

TABLE 3. Out-Year Effects of Gramm-Rudman-Hollings Deficit Reductions on Non-Defense Discretionary Spending, FY 1986-1991

	Enacted for 1986	After GRH cuts					
		1986	1987	1988	1989	1990	1991
Non-defense discretionary funding as percent of 1986 enacted budget authority:		(percent of 1986 enacted BA)					
(1) if programs continued without cuts and adjusted for inflation	100.0	100.0	104.1	108.0	111.5	114.6	117.0
(2) if GRH cuts occur	100.0	95.7	78.1	71.3	65.8	64.2	64.4
GRH funding levels (2) as percent of inflation adjusted 1986 funding (1)	100.0	95.7	75.0	66.0	59.0	56.0	55.0

Source: House Select Committee on Aging news release, January 28, 1986. Data for 1991 were extrapolated by Chambers Associates from data for earlier years.

APPENDICES

APPENDIX A: Summary of 1985 Report

The 1980s have been difficult years for those concerned with federal data collection and research that pertain to the aged. For some of the agencies involved, federal spending had already fallen in real purchasing power during the high-inflation years of the late 1970s, and Carter Administration reorganization efforts had affected the management of data collection and research. Then, in 1981, the incoming Administration implemented a new set of policies that affected most of these agencies adversely. Budgets were reduced, staff reductions were implemented, and policy research was de-emphasized.

These Reagan Administration policies sparked considerable protest from Members of Congress, largely in response to non-federal data users. Several Congressional hearings were held, journalists reported on potential problems raised by the cutbacks, and academics wrote on the implications of the Administration's plans.

While protests led to restoration of funding in some instances, significant reductions in data collection activities did occur. This paper describes those changes that are pertinent to the U.S. aged population. The aged are more dependent on federal benefits and services than is the population generally, and the economic, physical and social well-being of the aged are a major concern of policymakers. Furthermore, the aged population is changing dramatically in both size and composition as the "baby boom" cohort matures and as health care advances prolong life to older ages for large numbers of people.

Given the degree of attention focused on the aged, reduced data availability will be keenly felt. Research on social and economic issues will be limited; government program managers will know less about how well the aged are served; both public and private planning for health care and other age-related facilities will be hampered; and private businesses will know less about how the markets for their products and services will change. This paper addresses these audiences concerning what they will be losing. Since the paper's focus is on data losses, it does not deal with gaps in data that have persisted for many years.

The actual impacts of recent policies on data availability show up in a variety of forms:

- A number of existing surveys experienced reductions in the frequency with which they are fielded;
- Plans for new surveys were dropped or scaled back, and more reliance was placed on administratively generated data;
- Sample size reductions were implemented;
- Existing data series were discontinued in a few instances;
- Policy research was greatly reduced, with more emphasis given to program management analysis instead; and
- Valuable staff resources were lost, which may now threaten the quality of future activities in some agencies.

Despite these circumstances, there have been some improvements in data collection of interest to the aged, but the net result has been a reduction in data availability, a reduced federal capacity for policy research, and lessened federal support for non-government data analysis and research.

The main body of the paper reviews these developments, agency by agency. In this summary, an overview is provided of the most significant developments for each major topical area for which the federal government collects data on the aged.

A. Key Developments Affecting Data Availability

The material covered in this paper can be classified broadly into five data categories: general population data, income and wealth data, health data, labor force data, and data on housing and living arrangements. Although a particular survey may include data falling into more than one of these categories, this discussion treats them under the single category that is most appropriate.

1. General Population Data

The budget cuts of 1981-1982 were disruptive to the processing of the 1980 decennial census. As a result, publication dates are lagging behind the census year 12 to 18 months more than usual. Delays and resource constraints have forced cancellation of a number of Census Bureau publications, including several of interest to the aged, such as those on the older population, minority groups, poverty population characteristics, and structure of household income.

During the 1970s, Congress had authorized a mid-decade census to begin in 1985. Because of budget constraints, this new census was not funded.

2. Income and Wealth Data

It is in this area that the most serious problems have occurred since 1980. However, some new data collection activities have also been implemented.

The Survey of Income and Program Participation (SIPP) is an important new survey now in operation at the Census Bureau. However, its survival was in doubt after the Social Security Administration (SSA) terminated work on it in 1982. This disruption delayed SIPP's implementation during a time of major policy changes and a severe recession when its results would have been unusually valuable. The departure from the earlier plan eliminated SSA's plans to oversample the aged and to link survey data with program records.

A new SSA survey of the Supplemental Security Income (SSI) target population has been held up by the Office of Management and Budget (OMB). There is pressure to rely on SSI quality control data instead. A periodic survey of Food Stamp recipients has already been dropped by the Food and Nutrition Service (FNS) in favor of reliance on FNS quality control data.

Two new data collections are substantially expanding our knowledge of private pensions. One is the Survey of Consumer Finances, and the other is a special pension supplement to the Current Population Survey (CPS). On the other hand, the Department of Labor (DoL) has stopped publishing the Pension

Digest that summarized the rules for selected major pension plans. DoL also stopped collecting data on elderly budgets in various cities.

Policy research on income has been dealt a serious blow through cutbacks and reorganization. A large part of SSA's research staff has been transferred to the agency's operating divisions to do management studies. The Department of Health and Human Services' planning and evaluation office (DHHS/ASPE) has also been reduced in size, and extramural research has been cut back. The Administration on Aging (AoA) has greatly reduced its research funding, and the AoA Income Maintenance Policy Research Center may not be continued after 1985. The pension research program at DoL is less than half its former size, and the DoL research agenda is now focused mainly on pension investment and funding issues rather than on questions of coverage and benefit adequacy.

3. Health Data

Developments in the health area are mixed. Most of the health surveys have been stretched out to longer time cycles, and the responsible agency (the National Center for Health Statistics) has experienced particularly sharp cuts in both spending and staffing. Administrative data collection, on the other hand, has been expanded and improved by the Health Care Financing Administration (HCFA) due to pressures for better cost controls in the Medicare and Medicaid programs.

Health-related policy research is also a mixed situation. AoA may not continue its Health Policy Research Center after

1985, and the DHHS/ASPE Health staff has been reduced. HCFA has conducted large policy demonstrations through its authority to waive Medicare and Medicaid rules to test policy options, but OMB has recently taken control of waivers to limit the cost of such research. The National Institute on Aging has steadily increased its research program during this period and has been supportive of data collection both within its own program and through collaboration with other agencies.

4. Labor Force Data

Because of the aging of the U.S. population and concerns about earlier and earlier retirement ages, there has been growing interest in older workers and their retirement behavior. The data available for study of this subject is being reduced, however.

The Current Population Survey (CPS), the primary survey of employment status, has had its sample size reduced by nine percent. This reduction further limits the analysis that can be done for a population sub-group such as the aged that are not being oversampled.

One important longitudinal survey has been reduced in scope, and another has ended. The National Longitudinal Study (NLS), which began surveying working-age Americans in 1966, will discontinue data collection for the cohort of older men. The Retirement History Study (RHS) completed the last of six planned interview waves in 1979, and there are no plans to initiate a new study of the retirement process.

Related policy research has also suffered. AoA may not continue its Research Center on Older Workers after 1985, and it now sponsors few research grants in this area. The DoL policy research office has only about 40 percent of the staff resources it had in 1978, and it is not actively conducting any studies of this topic.

5. Data on Housing and Living Arrangements

The primary source of housing data, the Annual Housing Survey, was put on a biennial basis and renamed the American Housing Survey. This longer period between surveys will make the data less useful for some purposes such as the estimation of market rents in local areas.

The Department of Housing and Urban Development had made issues of concern to the elderly a major research priority during the 1970s. The aged are no longer a specific focus of research, thereby reducing the secondary data being produced on elderly housing.

Research funded on housing issues by AoA has also been sharply reduced, and the AoA Research Center on Housing and Living Arrangements was terminated.

B. Conclusion

Most data collections that existed prior to 1981 have been continued, and a few new ones have been added. However, there will be less detail available on the aged than would otherwise have been the case. The longer time lags between some surveys will reduce the accuracy of the data available on the aged.

There will be much less information than expected on the major income assistance programs serving the aged. The longitudinal data sets important to an understanding of individual behavior associated with aging will not be renewed. Available data have been improved on pension assets and on Medicare and Medicaid program operations.

While data collection activities have suffered mostly at the margins, the secondary data normally generated through policy research has been set back severely. Staff resources are much smaller, extramural research support has been greatly reduced, and the focus on research has shifted toward program management issues and away from analysis of policy options and target populations. It is here that budget and staffing changes have taken their greatest toll.

Should this circumstance continue, the government, and society generally, will lose the capability to assess the extent and nature of social problems and to evaluate the consequences of policies directed toward their resolution. We will know far less than we could know about the economic and social well-being of the aged and how their conditions will change as they grow older. We will understand far less about how older people respond to public policies designed to improve nutrition, influence retirement age, affect living arrangements, and guide health care utilization. The ultimate result will be that policy makers will necessarily rely more on popular perceptions about social needs and public programs and will rely less on objective findings reached through the application of social science principles.

APPENDIX B

A GUIDE TO FEDERAL RESPONSIBILITY FOR DATA SOURCES ON AGING

STAFF REPORT

Special Committee on Aging,
United States Senate
John Heinz, Chairman

March 1986

Staff Report of the
United States Senate
Special Committee on Aging

A Guide to Federal Responsibility for Data Sources on Aging

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GUIDE TO DATA SOURCES AND CONGRESSIONAL RESPONSIBILITY

	SENATE AUTHOR.	HOUSE AUTHOR.	SENATE APPRO.	HOUSE APPRO.	EXEC AGENCY
GENERAL POPULATION DATA					
1. Decennial Census	SG-1	HP-1	SA-1	HA-1	BOC
I INCOME					
1. Public Pensions:					
a. Survey of Income Program Participation (SIPP)	SG-1	HP-1	SA-1	HA-1	BoC
b. Supplemental Security Income (SSI) Survey	SF	WM-1	SA-2	HA-2	SSA/ HHS
c. Social Security Data Collection	SF	WM-1	SA-2	HA-2	SSA/ ORSIP
3. Private Pensions:					
a. Survey of Consumer Finances	SB-1	HB-1	SA-4	HA-4	FRB
b. Current Population Survey	SL	HE&L	SA-2	HA-2	BLS
c. Pension Digest	SL	HE&L	SA-2	HA-2	DOL
d. Consumer Expenditure Survey	SL	HE&L	SA-2	HA-2	DOL
II HEALTH					
1. General Population					
a. Health Interview Survey	SL	HE&C-1	SA-2	HA-2	NCHS
b. Health & Nutrition Examination Survey	SL	HE&C-1	SA-2	HA-2	NCHS
c. Long-Term Care Survey	SF/SL	EC/WM	SA-1	HA-1	HCFA/ASPE
d. Health Examination Survey	SL	HE&C-1	SA-2	HA-2	NCHS
e. Mortality Follow-back	SL	HE&C-1	SA-2	HA-2	NCHS

f. National Death Index	SL	HE&C-1	SA-2	HA-2	NHLBI
g. Baltimore Longitudnal Study of Aging	SL	HE&C-1	SA-2	HA-2	NIA
h. Medical Care Expenditure Survey	SL	HE&C-1	SA-2	HA-2	NCHSR
i. Survey of Personal Health Practices and Concequences	SL	HE&C-1	SA-2	HA-2	NCHS
j. Disability and Work	SP	WM	SA-2	HA-2	SSA
2. Special Populations					
a. Hospital Discharge Survey	SL	HE&C-1	SA-2	HA-2	NCHS
b. Ambulatory Medical Care Survey	SL	HE&C-1	SA-2	HA-2	NCHS
c. Long-Term Care Survey	SL/SP	E&C/WM	SA-2	HA-2	ASPE/HCPA
d. Nursing Home Survey	SL	HE&C-1	SA-2	HA-2	NCHS
e. Survey- Institutionalized Persons	SL	HE&C-1	SA-2	HA-2	ASPE
3. Service Utilization					
a. Ambulatory Care Survey	SL	HE&C-1	SA-2	HA-2	NCHS
b. Hospital Discharge Survey	SL	HE&C-1	SA-2	HA-2	NCHS
c. Mortality Follow-back	SL	HE&C-1	SA-2	HA-2	NCHS
d. Long-Term Care Survey	SL/SP	E&C/WM	SA-2	HA-2	ASPE/HCPA
4. Medical Professionals					
a. National Ambulatory Medical Survey	SL	HE&C-1	SA-2	HA-2	NCHS
b. National Nursing Home Survey	SL	HE&C-1	SA-2	HA-2	NCHS
5. Medicare Beneficiaries					
a. Patient Billing Data (Hospital)	SP	WM-2	SA-2	HA-2	HCPA

b. Medicare Provider File	SF	WM-2	SA-2	HA-2	HCFA
c. Hospital Cost and Utilization Project	SF	WM-2	SA-2	HA-2	HCFA
d. Medicare Cost Reports	SF	WM-2	SA-2	HA-2	HCFA
e. Contract Research	SF	WM-2	SA-2	HA-2	HCFA-1
IV LABOR FORCE PARTICIPATION					
1. Retirement					
a. Retirement History Study	SL	HE&C-1	SA-2	HA-2	SSA-1
b. Current Population Survey	SL	HE&C-1	SA-2	HA-2	BLS
2. Worker Characteristics					
a. National Long. Survey	SL	HE&L	SA-2	HA-2	DOL-1
b. Job Training Long. Survey	SL	HE&L	SA-2	HA-2	DOL-1
V HOUSING & NUTRITION SERVICES					
1. Housing					
a. American Housing Survey	SB-2	HB-2	SA-3	HA-3	HUD
3. Nutrition					
a. Health and Nutrition Examination Survey	SL	HE&C-1	SA-2	HA-2	NCHS
b. Annual Survey of Participants (Food Stamps)	S AGR.	H AGR.	SA-5	HA-5	DOA
VI OTHER AGE RELATED RESEARCH					
1. National Institutes of Health					
a. Institute on Aging b. Heart, Lung, & Blood Inst. c. Cancer Institute d. Eye Institute e. Arthritis, Diabetes, Digestive, Kidney Disease f. Neurological & Commun. Disorders & Stroke	SL	HE&C-1	SA-2	HA-2	NIH/PHS
2. Institute of Mental Health	SL	HE&C-1	SA-2	HA-2	ADAMHA

LEGEND - CONGRESSIONAL COMMITTEES

SENATE

SA = Senate Committee on Appropriations
SA-1 = SA Subcommittee on Commerce, Justice, State,
and Judiciary, and Related Agencies.
SA-2 = SA Subcommittee on Labor, Health and Human Services
SA-3 = SA Subcommittee on Housing on HUD-Independent Agencies
SA-4 = SA Subcommittee on Treasury, Postal Service, and General Govt.
SA-5 = SA Subcommittee on Agriculture, Rural Development and Related
S AGR= Senate Committee on Agriculture, Nutrition and Forestry
SB = Senate Committee on Banking, Housing, and Urban Affairs
SB-1 = SB Subcommittee on Financial Institutions and Consumer Affairs
SB-2 = SB Subcommittee on Housing and Urban Affairs
SG = Senate Committee on Governmental Affairs
SG-1 = SG Subcommittee on Energy, Nuclear Proliferation and Govt. Processes
SF = Senate Committee on Finance
SF-1 = SF Subcomittee on Health
SF-2 = SF Subcommittee in Social Security and Income Maintenance
SL = Senate Committee on Labor and Human Resources

HOUSE

HA = House Committee on Appropriations
HA-1 = HA Subcommittee on Commerce. Justice, State and Judiciary
HA-2 = HA Subcommittee on Labor-HHS
HA-3 = HA Subcommittee on HUD-Independent Agencies
HA-4 = HA Subcommittee on Treasury, Postal Service, General Govt.
HA-5 = HA Subcommittee on Agriculture, Rural Development, and Related
H AGR = House Committee on Agriculture
HB = House Committee on Banking, Housing and Urban Affairs
HB-1 = HB Subcommittee on Domestic Monetary Policy
HB-2 = HB Subcommittee on Housing and Community Development
HE&C = House Committee on Energy and Commerce
HE&C-1 = HE&C Subcommittee on Health
HE&L = House Committee on Education and Labor
HP = House Committee on Post Office and Civil Service
HP-1 = HP Subcommittee on Census and Population
WM = House Committee on Ways and Means
WM-1 = WM Subcommittee on Social Security
WM-2 = WM Subcommittee on Health

LEGEND - EXECUTIVE BRANCH

ADAMHA = Alcohol, Drug Abuse and Mental Health Administration
ASPE = Assistant Secretary for Planning and Evaluation - DHHS
BLS = Bureau of Labor Statistics - DOL
BOC = Bureau of Census - DOC
DHHS = Department of Health and Human Services
DOA = Department of Agriculture

DOL = Department of Labor
DOL-1 = Employment Training Administration - DOL
HCFA = Health Care Financing Administration - DHHS
HCFA-1 = Office of Research & Development - HCFA
HUD = Department of Housing and Urban Development
NCHS = National Center for Health Statistics - PHS - DHHS
NCHSR = National Center for Health Services Research - PHS - DHHS
NHLBI = National Heart, Lung, and Blood Institute - NIH - PHS - DHHS
NIA = National Institute on Aging - NIH - PHS - DHHS
NIH = National Institutes of Health - PHS - DHHS
PHS = Public Health Service - DHHS
SSA = Social Security Administration - DHHS
SSA-1 = Office of Research, Statistics, & International Policy- SSA - DHHS

DATA on AGING:

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DATA on AGING:
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SENATE COMMITTEE ON AGRICULTURE, NUTRITION AND FORESTRY

1. Annual Survey of Participants
   Food Stamp Program

HOUSE COMMITTEE ON AGRICULTURE

1. Annual Survey of Participants
   Food Stamp Program

SENATE COMMITTEE ON APPROPRIATIONS

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1. Decennial Census
2. Survey of Income Program Participation
3. Long-Term Care Survey

Subcommittee on Labor, Health and Human Services, Education and Related Agencies

1. Supplemental Security Income Survey
2. Social Security Data Collection
3. Current Population Survey
4. Pension Digest
5. Consumer Expenditure Survey
6. Health Interview Survey
7. Health & Nutrition Examination Survey
8. Health Examination Survey
9. Mortality Follow-back
10. National Death Index
11. Baltimore Longitudnal Study of Aging

12. Medical Care Expenditure Survey
13. Survey of Personal Health Practices and Concequences
14. Disability and Work
15. Hospital Discharge Survey
16. Ambulatory Medical Care Survey
17. Nursing Home Survey
18. Survey of Institutionalized Persons
19. Medicare Data
20. Retirement History Study
21. Job Training Longitudnal Survey
22. NIH
23. NIMH

Subcommittee on Housing and Urban Development-Independent Agencies

1. American Housing Survey

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1. Annual Survey of Food Stamp Participants

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1. Decennial Census
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1. Supplemental Security Income Survey
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21. Retirement History Study
22. Job Training Longitudnal Survey
23. NIH
24. NIMH

Subcommittee on Treasury-Postal Service-General Government

1. Survey of Consumer Finances

Subcommittee on Agriculture, Rural Development and Related Agencies

1. Annual Survey of Participants
   Food Stamp Program

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1. Survey of Consumer Finances

Subcommittee on Housing and Urban Affairs

1. American Housing Survey

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1. Survey of Consumer Finances

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5. Job Training Longitudnal Survey

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1. Health Interview Survey
2. Health & Nutrition Examination Survey
3. Health Examination Survey
4. Mortality Follow-back
5. National Death Index
6. Baltimore Longitudnal Study of Aging
7. Medical Care Expenditure Survey
8. Survey of Personal Health Practices and Concequences
9. Hospital Discharge Survey
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11. Nursing Home Survey
12. Survey Institutionalized Persons
13. Retirement History Study
14. Current Population Survey
15. NIH
16. NIMH

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2. Social Security Data Collection
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4. Long-Term Care Survey
5. Medicare Data

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Subcommittee on Energy, Nuclear Proliferation and Govt. Processes

1. Decennial Census
2. Survey of Income Program Participation
3. Long-Term Care Survey

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

1. Health Interview Survey
2. Health & Nutrition Examination Survey
3. Health Examination Survey
4. Mortality Follow-back
5. National Death Index
6. Baltimore Longitudnal Study Of Aging
7. Medical Care Expenditure Survey

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1. Decennial Census
2. Survey of Income Program Participation
3. National Long-Term Care Survey

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2. Medicare Data

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1. Supplemental Security Income
2. Social Security Data Collection

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June 19, 1986

Senator Charles E. Grassley
Chairman
Subcommittee on Aging
Committee on Labor and Human Resources
SH-404

Senator Thad Cochran
Chairman
Subcommittee on Energy, Nuclear Proliferation
and Government Process
Committee on Government Affairs
SH-605

Dear Senator Grassley and Senator Cochran:

I would like to commend the joint effort of your respective Subcommittees in organizing your hearing, Statistical Policy for an Aging America. You have focused the attention of Congress on the importance of interagency coordination with respect to the collection, analysis and utilization of data regarding the characteristics of older Americans and their households. I wish to take this opportunity to offer my brief comments for the hearing record.

Congress can not hope to meet the many challenges of an aging society without recognizing the fundamental importance of interagency cooperation in the development of data of substantially greater detail and higher quality than is currently available to Congressional policy makers. Of the numerous issues raised by the general subject matter of your hearing, I believe the following three specific objectives to be of principal concern:

1. The development of Federal data bases which will support detailed analysis of subpopulations among the elderly.

Contrary to prevailing stereotypes, older Americans are neither all impoverished nor all living in luxury. They represent a thoroughly heterogeneous population that in many respects is more diverse than any other. Very few common generalizations about older Americans -- with respect to income, health or other household characteristics -- are in fact true of the elderly as a group.

Currently many Federal data bases can not support detailed analysis of the population age 65 and over for subpopulations of great significance to policy makers. Among these important groups are minority elderly, the "old-old" (persons age 85 and over), and elderly persons living in specific living arrangements. There can be no progress toward more responsive Federal policy in the absence of such detailed data.

2. The improved integration of data on the economic resources of older Americans with other personal and household characteristics.

Congressional policy makers are often confronted with inadequate integration of data regarding specific characterisitics of a survey sample of the elderly -- especially health characteristics -- with relevant data regarding their economic resources. Not only does this undercut the ability of Congress to evaluate the income security needs of the elderly, but it also limits our understanding of health factors which may be linked to economic conditions.

3. The continued growth of longitudinal data bases.

Cross-sectional data on the characteristics of the population age 65 and over often conceal emerging trends among the elderly. Inferences drawn from such data are subject to severe distortions as a result of the constant entry of new cohorts into the elderly population.

There is a continuing need for expansion of current longitudinal data bases, particularly with respect to the economic resources of identified subpopulations within the elderly population.

Your initiative is an essential step toward the development of a body of research and information which will help policy makers to better understand the needs of older Americans and to better serve their needs. Unfortunately, the prevailing environment is not conducive to the realization of your objective. Statistics regarding the elderly are frequently misunderstood or misrepresented, and budgetary pressures undercut data gathering activities. However, by holding a joint hearing at this crucial time, you have helped give direction to Federal data gathering activities when such activities had reached an important crossroad.

Thank you for this opportunity to submit my comments for your hearing record. I look forward to the continued interest and activities of your Subcommittees with respect to these issues.

Sincerely,

Edward R. Roybal

Edward R. Roybal
Chairman

STATEMENT
for the
RECORD
# of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

Submitted to the

UNITED STATES SENATE

Committee on Labor and Human Resources
Subcommittee on Aging

and the

Committee on Governmental Affairs
Subcommittee on Energy, Nuclear Proliferation, and Government Processes

on

Statistical Policy in an Aging America

June 23, 1986

STATISTICAL POLICY IN AN AGING AMERICA

The American Association of Retired Persons (AARP), the nation's largest organization of persons aged 50 and over, with more than 22 million members, submits the following statement for the record regarding statistical policy for an aging America.

THE NEED FOR STATISTICAL INFORMATION

In our complex and "information-driven" society, the need for more adequate and timely information has increased exponentially. Not only because there are more Americans, but because there are and will be more older Americans, our data and information needs have escalated. To promote better understanding of our changing, aging society and to meet the challenges that those changes present for all institutions--governments, businesses, education and religious organizations, and families--it is imperative that public and private sector policymakers and decision-makers have access to more complete and more relevant information. This necessity has been noted in the Joint Economic Committee's March 1986 report, "Opportunities for Improving Economic Statistics."

The alternatives to timely, coherent, coordinated and comprehensive statistical information are inefficiencies in allocation of scarce resources by both governmental and non-governmental sectors--a situation we can ill afford, particularly in meeting the needs of the disadvantaged, both young and old. Through the combined effects of tight budgets compounded by Gramm-Rudman-Hollings, weakened coordination among statistical agencies, lack of management discretion in the allocation of funds, and protracted delays in updating statistical concepts, our statistical series are outmoded and there are too many data gaps.

We are in serious danger of losing some of the significant gains we have laboriously made in recent years. The solvency of the Social Security system, health care cost containment, and the appropriate amelioration of poverty can and will suffer from our lagging statistical response. By reducing our research and data collection efforts, we undertake planning efforts in these vital areas with one hand tied behind our backs.

THE NEED FOR STATISTICAL INFORMATION IN AN AGING AMERICA

That America is an aging society is no longer disputed. All current projections indicate that the number and proportion of persons aged 65 and over will increase markedly during the next fifteen years and well into the 21st century. This unprecedented graying of America means that we must have adequate and timely data on this very heterogeneous population, and on the pre-aged (ages 50-64) as well as the aged. Similarly, we must be able to track, in a longitudinal fashion, distinct subgroups among the elderly such as minorities, women and the "oldest-old" aged 85 and over, to meet their specific needs now and in the future. To determine how well those needs are being met and to make government and private programs for the aging and aged more effective, both baseline and trend data must be generated and monitored in all areas: income, wealth, health and mental health, housing and demography.

While statistics are often viewed as esoteric, arcane, and "dry as dust," there are multiple users of data on the older population that are gathered and disseminated by the federal government. Congress, the Executive Branch and the courts, as well as other national governments, for-profit businesses and non-profit and voluntary organizations rely on this information to develop products and health and social services. None of these users alone has sufficient resources to develop accurate and timely data.

Reductions in professional staff of statistics-gathering federal agencies and in sample sizes, both aggregated and disaggregated, seriously hamper our efforts to meet the challenges of our aging society, as do emerging trends in longer intervals between surveys. Threatened or actual reductions in force and ceilings on new personnel hiring over the past five to ten years are resulting in a loss of experienced statisticians without the necessary replacement by younger professionals, who are loath to consider a federal government career. Reductions in sample size will lead to our inability to disaggregate the elderly population and to provide meaningful age detail. This will lessen our ability to meet the markedly different needs of individuals who are aged 65 and those who are aged 85. Finally, increasing the time between surveys, especially in the health care area, means that the impacts of DRGs and Medicaid changes, and possibly negative consequences, cannot be evaluated in a timely fashion. The lack of information has severe implications for adequate planning by individuals and their families and the governmental and private sectors.

THE FEDERAL GOVERNMENT'S ROLE IN MEETING THIS NEED

All modern governments and their predecessors have long recognized the need for generating statistical information. As we know from The Bible and other sources, the Romans set up a census process for taxation purposes. Closer to our own legal history was the initiation by William the Conqueror of the Domesday Book and of course, the institution of the Decennial Census in 1790, shortly after the founding of our great nation. For almost two centuries, the federal government has played an increasingly important role in the collection of statistical data.

In a parallel fashion, pre-eminent thinkers such as John Stuart Mill and Thomas Jefferson recognized the importance of information and its free exercise as being the key to--one might say, the lifeblood of--the viability of democratic societies. The First Amendment to the Constitution and the court and legislative protections we have devised over nearly two hundred years attest to the high value we have placed on the free flow of information in the marketplace of ideas.

The federal government has a traditional and unique role in the collection of statistical information to facilitate that information flow. No other institution has such a compelling interest. The for-profit sector, with its focus on market penetration and three to five year planning cycles, does not have the necessary breadth of concerns or resources. Similarly, the non-profit, voluntary sector and state and local governments are constrained by resources and mission. Having a functioning, national statistical policy is as vital to our nation's well-being as having viable defense and trade policies.

AARP'S ROLE AND ASSISTANCE IN MEETING THIS NEED

As a voluntary membership organization focused on the concerns of older adults, understandably AARP does not command the resources necessary to fill in emerging statistical gaps through extensive data collection. However, both singly and in cooperation with other entities, AARP has perceived its responsibilities in providing statistical information about older Americans. Two editions of *Aging America: Trends and Projections* were developed in collaboration with the U.S. Senate Special Committee on Aging, the Federal Council on Aging, and the Administration on Aging of the Department of Health and Human Services. For several years, AARP has developed and disseminated a brochure, "A Profile of Older Americans," and most recently another pamphlet, "A Portrait of Older Minorities." Through its AARP Andrus Foundation, our organization has provided funding for projects such as the development of state profiles of the oldest-old for data-base planning in the field of aging. It should be noted, however, that all of this dissemination was based on federally collected data such as the National Health Interview Survey (NHIS), the Survey of Income and Program Participation (SIPP), and Current Population Surveys.

RECOMMENDATIONS

AARP recommends that a high priority be given to the objective of providing adequate funds for data collection and dissemination of statistical information about our aging American society. Specific recommendations to achieve this objective include:

- Promotion of an Interagency Forum and Task Force on Aging-Related Statistics to build upon the National Academy of Sciences' compendium of existing surveys and to promote and strengthen coordination among agencies responsible for data collection;
- Strengthening current surveys by restoring sample sizes in the SIPP and NHIS at least to their 1984 levels to avoid data gaps;
- Disaggregation of data about older Americans, both pre-aged and aged, into smaller age groups of five years to enhance longer range planning;
- Development of longitudinal data files that join socioeconomic and health data to reflect the interactive nature of the aging process;
- Creation and dissemination of more and better public use tapes that maintain confidentially;
- Establishment of mechanisms that promote the timely dissemination of statistical information about an aging America; and
- Resurrection of the Survey of the Aged and Disabled by the Social Security Administration designed to focus on those with low incomes.

AARP stands ready to play its continued dissemination role to help meet the needs for statistical information in an aging America and thereby to enhance the quality of life for older Americans, now and in the future.

T-53

Statement for the Record

by

Emily S. Andrews, Ph.D.

Submitted to the

U.S. Senate

Joint Hearing on Statistical Policy in an Aging America

Committee on Labor and Human Resources

Subcommittee on Aging

Subcommittee on Energy, Nuclear Proliferation,
and Government Processes

June 3, 1986

Emily S. Andrews is director of research for the Employee Benefit Research Institute. The views expressed in this statement are solely those of the author, and do not necessarily represent the views of the trustees and sponsors of the Employee Benefit Research Institute, or its staff.

Thank you for your invitation to submit written testimony for the record of the joint hearing held by the Subcommittee on Aging and the Subcommittee on Energy, Nuclear Proliferation, and Government Processes on the subject of Statistical Policy in an Aging America. The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan policy research organization committed to accurate and timely research and education on a wide range of public and employer-sponsored benefits, such as retirement and health insurance, and their role within the income security system of the nation. Since EBRI's founding in 1978, we have relied upon quality data provided by the federal government through its many statistical programs. Over the years, we have provided suggestions on continuing data needs to help researchers and policy analysts study retirement and health issues. For this reason, we welcome the opportunity to share our thoughts with the Subcommittees.

Despite some very positive steps in data collection over the past decade, the availability and timeliness of federal data has not entirely met the needs of researchers. We also fear reductions in data availability may occur in the future, when information on benefits and benefit recipiency will be even more crucial as the nation ages.

In addition, given the likely passage of tax reform legislation, we will need to know its impact on the pension and health plans upon which millions of workers and retirees depend. In the event of as far-reaching a change as basic tax reform, analysts and researchers cannot accurately foresee the future and reach reliable conclusions. Follow-up evaluation with up-to-date information will be necessary to evaluate its effect and correct for undesired impacts.

Our testimony discusses six specific areas of concern to the statistical community interested in issues related to aging in America.

I. Recent Initiatives

Two salutory new initiatives have been taken in recent years: the Survey of Income and Program Participation (SIPP) sponsored by the Census Bureau and the Survey of Consumer Finances (SCF) sponsored by the Federal Reserve Board and other federal agencies.

SIPP is a large, complex survey providing detailed information on many types of cash and in-kind income. As that survey continues, expanded technical support for the survey may also be needed. Without technical support, this complex data set is inaccessible.

While SIPP can serve many purposes, other special-purpose surveys should not be refused clearance by the Office of Management and Budget on the theory that SIPP can do everything. Some issues, such as the numbers and status of low-income elderly, the elderly in nursing homes, or the circumstances of the very old elderly, over age 85, may require separate surveys of special populations to achieve meaningful sample sizes.

The 1982 SCF is the first comprehensive survey of the assets of the population since the 1960s, when a similar attempt was funded by the Federal Reserve Board. It provides information on the distribution of personal assets including employer-sponsored pensions. Information on pension entitlement from employees was matched to employer data, providing the most complete data available. An ongoing survey of this type, in which savings can be tracked as with the aging of the population, would be invaluable to the research and policy community. It would also provide the Congress with a more reliable picture of the real economic condition of the elderly, in the event that reforms are considered in the various public programs.

II. Supplements to the Current Population Survey

In 1972, the Bureau of Labor Statistics, the Social Security Administration, and the Department of Treasury funded a survey conducted by the Census Bureau as a supplement to the Current Population Survey collecting information on pension plan participation and benefit entitlement among full-time private-sector workers. In 1979 the Department of Labor's Office of Pension and Welfare Benefit Programs conducted a similar survey on pension coverage and individual retirement account (IRA) utilization among all workers. In 1983 EBRI joined with the Department of Health and Human Services to conduct a similar survey including information on universal IRAs and 401(k) plans. The 1983 data have been used widely to analyze the effect of retirement income provisions found in current tax reform and retirement income legislative proposals. EBRI has proposed to fund a similar survey in 1988 in concert with the Social Security Adminstration. While as a private-sector nonprofit institution we are happy to sponsor a CPS supplement in conjunction with the federal government, we regret that the survey is not conducted on a yearly or biannual basis as an ongoing federal statistical program. Because Congress relies on private-sector programs to supplement benefits provided through the public sector, an ongoing federal statistical program of this nature would provide vital information on the extent and adequacy of such supplementation.

III. Level of Benefits Survey

Since 1979 the Bureau of Labor Statistics has collected detailed annual data from medium and large firms on the prevalence and provisions of pension, health, and other employer-sponsored benefits. This effort, often called the Level of Benefits Survey, in part replaced the Employer Expenditure Compensation Survey which was discontinued in the mid 1970s. The new effort is the only nationally representative source of benefits information. But it does not provide data on benefits offered by small employers. Although the Bureau of Labor Statistics is considering the addition of a small-employer sample in the future, this effort is not under active consideration within the next couple of years (although a survey of state and local governments may be on a faster track). Currently more than half of all American workers are employed in small establishments. These workers are potentially the most vulnerable to changes in public policy and benefits costs. With substantial current interest in the benefits provided by small employers, the small-employer segment ought to be conducted on an accelerated schedule. These data would also enable us to track trends in plan participation on a nationwide basis and to project those trends to the future.

IV. 5500 Annual Report Data

Since the Employee Retirement Income Security Act (ERISA) of 1974, most pension and welfare plans are required to file an annual report with the Internal Revenue Service which includes considerable financial information about these plans. No other data source provides comparable asset information. The Department of Labor receives copies of these forms under the reporting and disclosure provisions of ERISA. Since the first-year annual reports were filed (for plan year 1975), the research and policy community has hoped that the Department of Labor (or the Internal Revenue Service) would provide a statistically reliable sample of these annual report forms. Early years of data were available with a significant time lag and, despite a recent flurry of activity, the last plan year available for research use is for 1981 (although preliminary 1982 tabulations are available). These data constitute a potentially valuable resource to study the financial aspects of pension plans. Although the Federal Reserve Board is benchmarking the pension asset data in the Flow of Funds on the Department of Labor's 5500 forms, an ongoing funded statistical program is needed. Ad hoc efforts since 1974 are the result of resource limitations which forestalled an ongoing statistical program in this area.' These 5500 data are gathered by imposing considerable costs and effort on the private sector. To allow these valuable data to remain underutilized is a serious and unnecessary waste of the nation's resources.

V. Access Issues

The first three statistical concerns we discussed revolve around problems of irregular data collection. Our fourth concern, the 5500-form issue, is one of access and processing; the data are collected but are not available to researchers. Researchers would also benefit from more timely or accessible information from other administrative sources, including filings with the Internal Revenue Service for plans that have terminated and plans that are starting up. Better access to Pension Benfit Guaranty Corporation data, including information on plan terminations, would be valuable as well. Once again, neither of these agencies has an ongoing statistical program in many areas of concern.

Our final concern is that other data of an ongoing or one-time nature may be collected and processed adequately but then are not released in a timely manner. Problems of timely release have plagued the 1977 National Health Care Expenditures Study (NHCES) and the 1982 Nursing Home Survey. Public access to these data is slowed when they are only provided to certain researchers under contract to the agency or when information is held for researchers within the agency to use on a monopoly basis.

The Department of Labor Survey of Private Pension Benefit Amounts is another example of a data collection effort that has suffered from these problems. The survey has been available only to a limited number of researchers under contract to the Labor Department. Outside requests for use of the files has been sytematically denied. If this valuable research file is eventually released to the public when DOL now anticipates it will be, the information on benefits will be eight years out of date.

The release of these data also has been further encumbered because of another type of access problem. The Survey of Benefit Amounts was matched to earnings records from the Social Security Adminstration so researchers could track earnings throughout a retiree's entire career to investigate how pensions are related to lifetime earnings. Social Security earnings records have long been linked to survey data and released as public use files after ensuring that the information is not so specific that individuals can be identified from the data. This usually has involved the deletion of identifiers and removal of other unique information to ensure that that any one individual could not be pointed out. Based on interpretations of the 1976 Tax Reform Act, however, which, in essence, specifies that tax-return information cannot be released in microdata form without extreme safeguards, the continued public-use release of survey data matched with earnings records has virtually been precluded. This anomalous situation occurred because Social Security earnings are reported on Internal Revenue Service forms. The upshot of a series of incomprehensible negotiations on the part of the Social Security Administration and the Internal Revenue Service has been that, with very few exceptions, any survey that attaches earnings records has virtually been embargoed--whether there is any technical privacy reason or not. Researchers have begged both the agencies and the Congress to return authority over the earnings records to Social Security and to the pre-1976 situation, to no avail. Also, a major pension forecasting model may soon become outdated without additional earnings record data.

VI. New Data Sources

Many fear that in today's federal budget environment few new data sources will be developed. While the Social Security Administration conducted a major study of retirees with the New Beneficiary Survey, there is no assurance that another study of that type will be funded. Their longitudinal Retirement History Study provided researchers with one of the major databases to study the retirement decision and the income of the elderly. Other longitudinal data such as the National Longitudinal Survey funded by the Department of Labor have also ended. While we do not argue that either of these surveys should be resuscitated (many technical factors would go into that decision), we do argue for the need for longitudinal data to respond to many of the policy research questions about an aging labor force and retirement--questions that more and more congressional committees are asking. In a changing society, information about individuals in the 1970s may provide little information on the behavior of workers and retirees in the 1990s.

Conclusion

We feel that all the data issues we have raised are vital to understanding an aging society. We understand data gathering is costly and that difficult decisions must be made. We have tried to be specific in our suggestions and have not presented a "wish list" of data needs without regard to importance.

Clearly, it is possible for the federal government to be penny-wise and pound-foolish in data collection. Public policy must continue to be grounded on a firm understanding of the facts; the facts are only available with a good statistical foundation and reliable research. We applaud the Subcommittee for this inquiry into this important subject and remain willing to provide further assistance if you should desire it.

Health Care Financing Administration
Statement For The Record
Joint Hearing on Statistical Policy for An Aging America
June 3, 1986

The Health Care Financing Administration (HCFA) appreciates this opportunity to describe for the record of your joint hearing on statistical policy for an aging America our most important data collection and dissemination activities relating to the elderly.

As an observer at the recent Summit Meeting on Aging Related Satistics, co-sponsored by the National Institute on Aging and the U.S. Bureau of the Census, HCFA looks forward to exploring the possibility of new opportunities for linkage of records relating to the elderly and greater coordination of data among Federal agencies that the proposed Interagency Forum shows promise of fostering.

Unlike many of the agencies represented at that Summit Meeting, HCFA is not primarily a research and data collection organization. The Agency was established within the Department of Health and Human Services to combine health financing and quality assurance programs within a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, and a variety of other health care quality assurance programs. Its mission is to promote the timely delivery of appropriate, quality health services to its beneficiaries--approximately 50 million of the nation's aged, disabled, and poor. The agency is also charged with ensuring that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality, and that agency policies and actions promote efficiency and quality within the total health care delivery system.

Thus, while research and data collection activities are not HCFA's chief function, they are a fundmental component of the agency's mission. The ongoing data gathering associated with administering the nation's two largest Federally-financed health care programs has made us a significant repository within the Federal Government of primary data on the elderly and disabled. In particular, Medicare files contain information on more than 95 percent of the aged individuals in the United States.

Because these files represent such a rich potential resource for health policymaking and research, including epidemiolgic studies, making them accessible, within limits imposed on their confidentiality by the Privacy Act and other considerations, became a significant challenge for HCFA. Moving from a policy during the Medicare program's first ten years that prevented release of individually identifiable data for purposes not directly related to the program, HCFA has in recent years initiated or facilitated the carrying out of a growing number of cooperative studies and other data sharing arrangements. These range from co-sponsorship of periodic major national health surveys such as the upcoming National Medical Expenditures Survey (NMES), to the support of a wide variety of Federal record linkage activities conducted through interagency agreements. In addition to expanding the availability of primary data from HCFA's data bases, HCFA also publishes a variety of research and statistical reports that make available additional statistics and tabulations from HCFA's primary files.

ORGANIZATION OF HCFA DATA COLLECTION AND RESEARCH ACTIVITIES

Within HCFA, three organizations have primary responsibility for research and data collection. The Office of Research and Demonstrations (ORD) conducts studies and projects that demonstrate and evaluate optional reimbursement, coverage, eligibility and management alternatives to the present Federal programs. In addition, ORD examines the impact of HCFA programs on health care status, utilization, and expenditures, as well as their effect on beneficiary access to services, health care providers, and the health care industry.

The Office of the Actuary directs the actuarial program for HCFA and monitors national health care expenditures and prices. OACT also provides analyses on the costs of current HCFA programs and the impact of possible legislative or administrative changes in the programs.

The Bureau of Data Management and Strategy (BDMS) operates HCFA's statistical data system and maintains the national Medicare statistical files. BDMS also serves as the focal point within the agency for information systems policy, planning, and data standards development.

HCFA'S MAJOR DATA BASES

The Medicare Statistical System (MSS), annual aggregate data derived from State Medicaid Management Information System (MMIS) files, and data from the 1980 National Medical Care Expenditures Survey (NMCUES), are currently HCFA's most important statistical data bases. A new comprehensive National Medical Expenditure Survey (NMES), sponsored by HCFA and the National Center for Health Services Research, will be carried out in 1987.

Of these three major HCFA data bases, the MSS is the most complete and versatile. In operation since 1966, the system combines several administrative record systems that are centrally maintained in the operation of the Medicare program. Three principal files are the Health Insurance Master File, which contains a record on each of the approximately 30 million aged and disabled Medicare enrollees; the Provider of Services File, containing descriptive information by provider number on every one of the nearly 28,000 facilities that

PARTICIPATE IN MEDICARE AND/OR MEDICAID; AND THE UTILIZATION FILE, WHICH CONTAINS CENTRALLY PROCESSED MEDICARE DIAGNOSIS, PROCEDURE, BILLING, AND REIMBURSEMENT INFORMATION.

UTILIZATION RECORDS WITHIN THE MSS CAN BE MATCHED TO ENROLLMENT AND PROVIDER RECORDS, PROVIDING THE BASIS FOR DEVELOPING POPULATION-BASED STATISTICS. THE MSS ALSO SUPPORTS CONSISTENT LONGITUDINAL AND CROSS-SECTIONAL ANALYSES. BECAUSE BOTH THE LOCATION OF THE ENROLLEE AND PROVIDER ARE KNOWN, GEOGRAPHIC DISAGGREGATION IS POSSIBLE DOWN TO THE ZIP CODE LEVEL. LINKAGES ACROSS UTILIZATION, ENROLLEE, AND PROVIDER FILES ENABLE THE CALCULATION OF UTILIZATION RATES FOR NUMEROUS COHORT GROUPS DEFINED BY AGE, RACE, SEX, GEOGRAPHIC RESIDENCE, AND TYPE OF SERVICES USED.

THE MSS IS MASSIVE IN VOLUME, AND EVEN COMPONENTS OF IT ARE CUMBERSOME TO USE. FOR EXAMPLE, IN 1984, ABOUT 12 MILLION INPATIENT HOSPITAL BILLS, 30 MILLION OUTPATIENT HOSPITAL BILLS AND 150 MILLION PHYSICIAN/SUPPLIER PAYMENT RECORDS WERE RECEIVED AND PROCESSED WITHIN THIS FILE.

IN ORDER TO FACILITATE ACCESS TO PRIMARY STATISTICS WITHIN THE MSS, HCFA MAINTAINS A SUMMARY FILE ON A CONTINUOUS ANNUAL BASIS WHICH LINKS DATA COVERING ALL MEDICARE BENEFITS ON A 5 PERCENT SAMPLE OF BENEFICIARIES' CHARACTERISTICS. BENEFICIARY CHARACTERISTICS AND DATA ON EACH HOSPITAL AND SKILLED NURSING FACILITY STAY ALONG WITH DIAGNOSTIC AND SURGICAL INFORMATION ARE INCLUDED IN THIS CONTINUOUS MEDICARE HISTORY SAMPLE (CMHS), WHICH CAN BE USED AS A LONGITUDINAL STATISTICAL DATA BASE TO STUDY UTILIZATION OF MEDICARE BENEFITS. IN ADDITION, HCFA IS CURRENTLY IMPLEMENTING A NEW MEDICARE AUTOMATED DATA RETRIEVAL SYSTEM (MADRS), WHICH IS DESIGNED TO REORGANIZE AND INDEX THE MASSIVE MEDICARE 100 PERCENT BILL AND RECORD PAYMENT FILE. THIS PROJECT WILL MAKE IT EASIER AND LESS EXPENSIVE TO RETRIEVE DATA FOR RESEARCH AND DEMONSTRATION PURPOSES. MADRS WILL CONTAIN 100 PERCENT OF HOSPITAL BILLS, OUTPATIENT BILLS, SKILLED NURSING FACILITY BILLS, AND PHYSICIAN AND SUPPLIER PAYMENT RECORDS. THE SYSTEM WILL INCLUDE FOR THE FIRST TIME BOTH PART A AND PART B CLAIMS RECORDS.

PUBLICATIONS, INCLUDING THE HEALTH CARE FINANCING PROGRAM STATISTICS SERIES MAKE AVAILABLE MEDICARE STATISTICS ON BENEFICIARY UTILIZATION BILLED CHARGES AND REIMBURSEMENT FOR EACH COVERED SERVICES. REPORTS ARE ALSO PREPARED ON CHARACTERISTICS OF THE MEDICARE BENEFICIARY POPULATION AS WELL AS THE PROVIDERS OF SERVICES.

HCFA DOES NOT ROUTINELY RECEIVE ANY INDIVIDUAL DATA ON MEDICAID ELIGIBLES AND RECIPIENTS OR ON PAYMENTS MADE FOR MEDICAL SERVICES PROVIDED. THE STATES ARE, HOWEVER, REQUIRED TO REPORT AGGREGATE STATISTICS ON THE MEDICAID PROGRAM TO THE FEDERAL GOVERNMENT. FOR RESEARCHERS INTERESTED IN THE ELDERLY, THE MOST IMPORTANT SOURCE OF NATIONAL MEDICAID DATA IS THE ANNUAL HCFA-2082 FORM, WHICH COLLECTS

INFORMATION ON RECIPIENTS AND ON EXPENDITURES BY TYPE OF RECIPIENT AND BY TYPE OF MEDICAL SERVICE, AS WELL AS DEMOGRAPHIC INFORMATION AND UNITS OF SERVICE FOR LONG TERM CARE AND SELECTED MEDICAL PROVIDERS. THIS CLAIMS FILE DATA IS PART OF THE MEDICAID MINIMUM DATA SET (MMDS), WHICH IN TURN IS A SUBSET OF THE STATE'S MEDICAID MANAGEMENT INFORMATION SYSTEM, (MMIS). A MEDICAID FINANCIAL DATA SET, CONSISTING OF INFORMATION SUBMITTED TO HCFA FOR INTERNAL BUDGET AND REIMBURSEMENT PURPOSES IS ALSO PART OF THE MMIS, BUT ONLY DATA FROM THE MMDS ARE ROUTINELY MADE AVAILABLE FOR RESEARCH PURPOSES.

MEDICAID 2082 DATA ARE CONSIDERABLY LESS POWERFUL THAN MSS DATA. POPULATION-BASED UTILIZATION RATES CANNOT BE CALCULATED. LONGITUDINAL AND CROSS-SECTIONAL COMPARISONS ARE ALSO LIMITED BY THE FACT THAT NOT ALL STATES HAVE REPORTED UNIFORMLY SINCE THE 2082 DATA BASE BECAME ESTABLISHED IN 1973. WHILE THE MEDICAID 2082 DATA REPRESENT LIMITED ANALYTIC CAPACITY, THE SIZE OF THE DATA BASE IS RELATIVELY MANAGEABLE. A COMPUTERIZED VERSION OF ITS MAJOR COMPONENTS SPANNING THE YEARS 1975 TO 1982 IS AVAILABLE TO THE PUBLIC. ADDITIONAL DATA ARE ROUTINELY MADE AVAILABLE IN TWO HCFA PUBLICATIONS: THE NATIONAL ANNUAL MEDICAID STATISTICAL REPORT AND THE MEDICARE AND MEDICAID DATA BOOK

BECAUSE OF THE LIMITS INHERENT IN MEDICAID'S 2082 DATA BASE, HCFA DEVELOPED THROUGH A SPECIAL "TAPE-TO-TAPE" PROJECT, A LIMITED PERSON-LEVEL DATA BASE ON THE MEDICAID POPULATION. SPANNING ONLY THE YEARS 1980-83, THIS DATA BASE INCLUDES

MEDICAID RECIPIENTS IN ONLY FIVE STATES. HOWEVER, THESE STATES (NEW YORK, CALIFORNIA, MICHIGAN, GEORGIA, AND TENNESSEE) ENCOMPASS A LARGE PERCENTAGE OF THE NATIONAL MEDICAID POPULATION. WITHIN HCFA, THIS DATA BASE IS CURRENTLY BEING LINKED TO MEDICARE DATA FOR A STUDY OF ELDERLY PERSONS WHO ARE DUALLY ELIGIBLE FOR THE MEDICAID AND MEDICARE PROGRAMS. THERE ARE NO CURRENT PLANS TO PRODUCE PUBLIC USE TAPES OF THIS DATA. SINCE 1953, THE FEDERAL GOVERNMENT HAS AT INTERMITTENT INTERVALS CONDUCTED SEVEN SURVEYS OF NATIONAL HEALTH CARE UTILIZATION AND EXPENDITURES. THE MOST RECENT OF THESE, THE NATIONAL MEDICAL CARE UTILIZATION AND EXPENDITURE SURVEY (NMCUES), WAS CO-SPONSORED BY HCFA AND THE NATIONAL CENTER FOR HEALTH STATISTICS (NCHS). NMCUES DATA REFLECT THE HEALTH CARE EXPERIENCE OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION OF THE UNITED STATES DURING 1980. THE SURVEY WAS DESIGNED WITH SPECIAL EMPHASIS ON THE EXPERIENCE OF MEDICARE AND MEDICAID BENEFICIARIES. THE DATA BASE CONSTRUCTED FROM NMCUES MERGES ELIGIBILITY AND REIMBURSEMENT DATA FROM MEDICARE AND MEDICAID ADMINISTRATIVE FILES WITH INTERVIEW DATA DERIVED FROM A SERIES OF QUESTIONNAIRES ADMINISTERED TO A RANDOMLY SELECTED NATIONAL HOUSEHOLD SAMPLE PANEL OF THE CIVILIAN NONINSTITUTIONAL POPULATION AND A FOUR-STATE RANDOMLY SELECTED MEDICAID HOUSEHOLD SAMPLE PANEL.

THE NMCUES DATA BASE, COMPLETED AND MADE AVAILABLE TO THE PUBLIC IN 1983, PRODUCES A COMPOSITE PICTURE OF COVERAGE, SERVICE USE, AND expenditure patterns for Medicare and Medicaid enrollees. It thus augments the types of analyses that can be conducted on beneficiaries and enables comparisions of beneficiary to nonbeneficiary population. It should be noted, however, that while surveys have decided strengths, they are very expensive and complicated in actual use. Hence they are infrequently undertaken. While the data sets from NMCUES and earlier surveys have served health care policy makers and analysts well, they will be long out of date by 1987, when the next survey in the series, the National Medical Expenditure Survey (NMES), is scheduled to be undertaken.

DATA SHARING ARRANGEMENTS

Access to HCFA files has been opened for a wide variety of health research projects during the past decade. HCFA rountinely shares data with other agencies within the Department; with our grantees and contractors; with Congress and its agencies, including the Office of Technology Assessment, Congressional Budget Office, and Congressional Research Service; with oversight agencies, including the GAO and the Department's Office of Inspector General; with Government Commissions, including the Prospective Payment Assessment Commission; and, to a lesser extent, with other Government agencies, such as the Veterans Administration. Infrequently, data are also furnished for privately funded studies under stringent formal requirements.

These data sharing arrangements are normally undertaken to facilitate policy development and for purposes of serious programmatic and basic research. Care is taken to assure that when disclosing data in HCFA files on Medicare beneficiaries that contain individual identifiers, the provisions of the Privacy Act of 1974 (and section 1106(a) of the Social Security Act) are followed and properly enforced. Generally, the Privacy Act prohibits disclosure of such data except under one of its specific disclosure provisions. For example, one of these provisions allows disclosure by one employee of an agency to another employee of the same agency on a need-to-know basis.

Since all of HHS is considered to be a single agency, HCFA is able to release data to components of the Public Health Service and to the Social Security Administrations after establishing the validity of the need.

Individually identifiable data can be released outside the agency for purposes which are compatible with the purposes for which the data were collected, under the so-called "routine use" provision. Release of data to HCFA contractors and State agencies is made under this provision.

HCFA has also developed a "routine use" category for release of data to outside individuals and organizations for research that is determined to be compatible with program purposes and is important and soundly

DESIGNED. FOR EXAMPLE, TO MEET THE NEEDS OF THE AMERICAN HOSPITAL ASSOCIATION AND SIMILAR ORGANIZATIONS, A FILE CALLED THE "MODIFIED MEDPAR FILE" WAS DEVELOPED FROM MEDICARE DATA ON A SAMPLE OF BENEFICIARIES DISCHARGED FROM SHORT-TERM HOSPITALS. THE FILE CONTAINS DETAILED INFORMATION ON SERVICES, CHARGES, AND DIAGNOSES OF BENEFICIARIES IN THE SAMPLE. PROTECTION OF BENEFICIARY PRIVACY IS INSURED BY DELETION OF ALL DATA ELEMENTS LIKELY TO PERMIT IDENTIFICATION OF INDIVIDUAL BENEFICIARIES. TO BUTTRESS THIS PROTECTION, USERS OF THIS FILE ARE REQUIRED TO SIGN AN AGREEMENT TO PROTECT THE DATA FROM ANY EFFORT TO DEDUCE INDIVIDUAL BENEFICIARY IDENTITIES.

UNDER ADDITIONAL PRIVACY ACT PROVISIONS, HCFA ALSO RELEASES DATA TO THE U.S. BUREAU OF THE CENSUS, LAW ENFORCEMENT AGENCIES, AND PURSUANT TO COURT ORDER.

CURRENT INTERAGENCY COOPERATIVE EFFORTS

HCFA ENGAGES IN NUMEROUS COLLABORATIVE PROJECTS WITH OTHER FEDERAL AGENCIES DESIGNED TO LINK MEDICARE CLAIMS DATA WITH DATA FROM OTHER SOURCES IN ORDER TO INCREASE OUR COLLECTIVE UNDERSTANDING OF ASPECTS OF AMERICA'S AGING POPULATION.

TWO MAJOR PROJECTS THAT LINK MEDICARE DATA WITH INFORMTION FROM THE SOCIAL SECURITY ADMINISTRATION (SSA) ARE CURRENTLY UNDERWAY. ONE STUDY LINKS THE CONTINUOUS MEDICARE HISTORY SAMPLE (CMHS), TO SSA'S CONTINUOUS DISABILITY HISTORY FILE, A FILE REPRESENTING FROM 5 TO 20 PERCENT OF EACH STATE'S NEWLY AWARDED DISABLED POPULATION IN 1975. THE STUDY IS FOLLOWING THE MEDICARE EXPERIENCE OF PERSONS AWARDED DISABILITY IN 1975 FROM 1977 TO 1981. A SECOND PROJECT, LINKING THE CMHS WITH SSA'S CONTINUOUS WORK HISTORY SAMPLE, IS IN THE PLANNING STAGES WITH LINKAGE EXPECTED LATER IN 1986. SSA'S ONE PERCENT LONGITUDINAL SAMPLE OF EARNINGS HISTORIES FROM 1937 TO 1982 WILL BE LINKED TO MEDICARE FILES, AS WILL THE SSA FILE CONTAINING RECORDS BY EMPLOYER AND INDUSTRY THAT RUNS FROM 1957 TO 1982. THE SSA DATA ARE REGARDED AS QUITE SENSITIVE BECAUSE THEY CONTAIN RECORDS OF TAXABLE EARNINGS THAT SSA CANNOT RELEASE UNDER THE PRIVACY ACT, EVEN FOR RESEARCH PURPOSES. TO SOLVE THIS PROBLEM, HCFA IS PROVIDING SSA WITH THE MEDICARE DATA NEEDED TO MAKE THE LINKAGE AND ALL DATA PROCESSING WILL BE DONE BY SSA. INITIALLY, HCFA PLANS TO USE THE DATA RESULTING FROM THIS LINKAGE TO STUDY MEDICARE UTILIZATION ON THE PART OF ELDERLY BENEFICIARIES BY INDUSTRY OF PREVIOUS EMPLOYMENT.

HCFA IS ALSO PARTICIPATING IN A NUMBER OF JOINT STUDIES WITH THE NATIONAL CENTER ON HEALTH STATISTICS THAT INVOLVE LINKING MEDICARE CLAIMS DATA WITH INFORMATION OBTAINED FROM INTERVIEWS. AN EXAMPLE OF THESE IS THE 1986 NATIONAL MORTALITY FOLLOWBACK SURVEY, THROUGH WHICH NCHS IS COLLECTING INFORMATION ABOUT THE HEALTH AND USE OF SERVICES IN THE LAST YEAR OF LIFE FROM THE NEXT OF KIN OF PERSONS DYING IN 1986.

The study will link a sample of death records to HCFA's Medicare records, permitting greater opportunities for statistical analysis than would otherwise result from interviews with relatives.

In addition to these data linkage activities, HCFA actively sponsors large-scale national surveys of health care focused on the elderly. For example, two successive Long Term Care Surveys, co-sponsored by HCFA and HHS' Office of the Assistant Secretary for Planning and Evaluation, were conducted in 1982 and 1984. These surveys asked detailed questions of samples of functionally impaired Medicare beneficiaries. Data collection was carried out by the U.S. Census Bureau. Public use tapes are available for 1982 and are in development for 1984 data. The survey of most current interest is the National Medical Expenditure Survey (NMES), scheduled for 1987. NMES is designed to provide needed data on the elderly population. Functionally impaired persons will be oversampled, many of whom are elderly. Also, for the first time both noninstitutionalized and institutionalized populations will be included in the same survey. The nursing home sample will be predominately elderly. This survey will provide utilization and expenditure data for individuals in institutions as well as those in the community. Special efforts will be made to collect data on home health care.

NMES is the best example of which HCFA is aware of efforts being made to collaborate among a number of Federal agencies with responsibilities for collecting data on the elderly. The survey will be jointly administered by HCFA and the National Center for Health Services Research (NCHSR). The National Center for Health Statistics (NCHS) will assume a supporting role, providing consultation and technical advice as available resources permit. HCFA's primary concern is with utilization and expenditure data for persons in the Medicare and Medicaid populations. NCHSR will use the data for policy research on key national health issues, including the effects of proposals to change patterns and levels of use and expenditures as well as the structure of private health insurance and Federal financing programs. The National Institute of Mental Health will focus on patterns of community versus institutional care and related reimbursement patterns of persons with and without mental illness. NMES will be used by the Indian Health Service (IHS) to ascertain all health care resources (IHS and non-IHS) being utilized by American Indians and Alaska Natives and to estimate associated charges and sources of payment.

An important adjunct to HCFA's collaborative data collection activities and cooperative research efforts is the agency's sponsorship of scholarly studies aimed at improving Federal data resources. Through an interagency agreement with the National Science Foundation, HCFA provides support for the Foundation's Committee on National Statistics. The Committee is composed of distinguished statisticians who work to improve the statistical methods and statistical information on which public decisions are based. Projects deemed of potential national significance are identified for study.

ONE SUCH STUDY WHICH HCFA IS SUPPORTING IS THE PANEL ON STATISTICAL PROBLEMS IN POLICY ANALYSIS FOR AN AGING POPULATION, CURRENTLY BEING CONDUCTED BY THE NATIONAL ACADEMY OF SCIENCES. HCFA IS ONE OF SEVEN FEDERAL AGENCIES SPONSORING THIS TWO-YEAR NAS PANEL, WHICH IS EXAMINING A BROAD RANGE OF ISSUES INVOLVING AGING-RELATED STATISTICS. THE PANEL'S CONCERNS INCLUDE THE ADEQUACY OF CURRENT DATA RESOURCES FOR HEALTH POLICY ANALYSIS OF THE AGED. UPON COMPLETION, IN SEPTEMBER 1986, STUDY RECOMMENDATIONS ARE EXPECTED CONCERNING FUTURE DATA COLLECTION ACTIVITIES, DATA GAPS, AND IMPROVEMENTS IN STATISTICAL METHODOLOGY. ONE PRODUCT OF THE STUDY WILL BE AN INVENTORY OF AVAILABLE DATA SETS ON THE AGING POPULATION.

CONCLUSION

IN SUMMARY, HCFA OFFERS EXTENSIVE PRIMARY DATA RESOURCES FOR RESEARCH INTO ISSUES RELATING TO THE ELDERLY. OVER THE PAST TEN YEARS, THE AGENCY HAS GRADUALLY OPENED ACCESS TO ITS DATA FILES UNDER PROTECTIVE PROCEDURES WHICH RESULT IN MINIMAL INTRUSION INTO THE PRIVACY OF BENEFICIARIES. CURRENT DATA SHARING ARRANGEMENTS HAVE BEEN ACHIEVED THROUGH INDIVIDUAL INTERAGENCY AGREEMENT AS WELL AS THROUGH HCFA'S ACTIVE PARTICIPATION IN FORMAL AND INFORMAL DISCUSSIONS WITH OTHER FEDERAL AGENCIES AND QUASI-GOVERNMENTAL ORGANIZATIONS CONCERNED WITH IMPROVING THE RELEVANCY AND AVAILABILITY OF DATA ON THE AGING.

THE ASSISTANCE THAT HCFA PROVIDES IN MAKING ITS FILES ACCESSIBLE HAS ALWAYS BEEN CONTINGENT UPON THE AVAILABILITY OF SUFFICIENT RESOURCES, SINCE EVERY APPROVED REQUEST FOR DATA GENERALLY HAS TO BE PRODUCED INDIVIDUALLY BY A STAFF WHOSE PRIMARY RESPONSIBILITY IS TO PREPARE DATA FOR INTERNAL PURPOSES. THEREFORE, WHILE WE SHARE THE ENTHUSIASM FOR THE CONCEPT OF AN INTERAGENCY FORUM ON AGING RELATED STATISTICS THAT WAS SO APPARENT AT LAST MONTH'S SUMMIT CONFERENCE, IT WOULD BE UNREALISTIC TO IGNORE THE REALITY THAT ANY SUBSTANTIAL GROWTH IN THE LEVEL OF INTERAGENCY ASSISTANCE HCFA PROVIDES WOULD REQUIRE CAREFUL EVALUATION OF THE IMPACT ON ITS BUDGET AND RESOURCE AVAILABILITY.

NASUA
NATIONAL ASSOCIATION OF STATE UNITS ON AGING
(202) 484-7182

NATIONAL ASSOCIATION OF AREA AGENCIES ON AGING
(202) 484-7520

June 19, 1986

Ms. Penny Bogas
Subcommittee on Aging
428 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Ms. Bogas:

Thank you for the opportunity to submit testimony on the important issue of a statistical policy in an aging America. As representatives of the 57 State Units and 667 Area Agencies on Aging, NASUA and NAAAA recognize that timely and accurate information is essential for the effective planning and management of services for older persons.

In this regard, we are currently pursuing several initiatives which are designed to collect and present information in a manner useful for decision making at the national, state and local level, both within and outside of government.

The first of these is the National Data Base on Aging, a repository of statistical information on the programs of State Units and Area Agencies, which is available to individuals, agencies and organizations with an interest in services for older persons. A detailed description of this information resource is attached for inclusion as part of our testimony.

In an effort to encourage state and local agencies to make effective use of available information, two other initiatives have been undertaken. These are:

- o Catalogs of Microcomputer System Applications for Area Agencies and State Units on Aging, designed to encourage replication of effectively operating information management systems.
- o A model to forecast service needs of the elderly at the state and local level, based on the concept of functional impairment.

We applaud your efforts to help guarantee access to relevant information on the elderly and programs which serve them. If you have questions about any of our related initiatives please feel free to contact us.

Sincerely,

Daniel A. Quirk
Executive Director
NASUA

Raymond C. Mastalish
Raymond C. Mastalish
Executive Director
NAAAA

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THE NATIONAL DATA BASE ON AGING

AN INFORMATION RESOURCE YOU SHOULD KNOW ABOUT

Professionals in the field of aging have long recognized the need for timely and accurate data to support program management, services development, and research functions. Today, computer information systems which present data that can be used in decision making and analysis are helping to meet this need.

Recognizing the aging network's need for high quality information, the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (NAAAA) have developed the National Data Base on Aging to provide precise information on the characteristics, activities, and services of State and Area Agencies on Aging.

Annual Surveys Conducted

The DATA BASE was initiated to test the feasibility of using a voluntary system to collect information at the national level about the programs of State and Area Agencies on Aging. The joint effort undertaken by NASUA and NAAAA and funded, in part, by the Administration on Aging, involves an annual questionnaire survey of all State Units and a one-third sample of Area Agencies.

The DATA BASE represents the first major initiative conducted at the national level to compile comparable information about all activities and services supported by this network. It was designed to address several major problems.

- The sparsity of timely and accurate data about SUA's and AAA's and their associated services and activities for older persons;
- The lack of data comparability, given the range of service definitions in use; and
- The lack of useful feedback of information to those agencies that have provided data from time to time.

The DATA BASE has addressed these problems in several ways:

- Through a systematic approach for ongoing data collection;
- By employing a uniform set of service definitions for consistently compiling network program activities; and
- By involving intended beneficiaries and respondents of the DATA BASE in all phases of the project's design and implementation.

How Can The Data Be Used?

Current DATA BASE users include market research consultants, journalists, business and industry, in addition to State and Area Agencies. Several examples illustrate the ways in which the DATA BASE can be used:

- A university professor conducting a study on nutritional services for the elderly contacted the DATA BASE for information on 10 Area Agencies on which he was basing his study. The DATA BASE supplied information on the number of persons receiving services, their characteristics, the number of meals served, and the cost. The availability of this information saved the researcher and the AAA's significant time and expense.
- A State Unit on Aging in the midwest planned to push for state dollars to fund a program that would enable elderly persons to receive home health care. The DATA BASE provided models of similar programs being implemented successfully in other states.
- An Area Agency director called the DATA BASE to find out how the level of local funds in his area compared to other locales with similar levels of population and urbanization. When the information provided showed that his financial support was low by comparison, he presented the data to his city council and obtained an increase in local funding.
- An insurance company contacted the DATA BASE for information on Area Agencies that use their own staff and vehicles to transport older persons. The company intended to offer an insurance plan covering transportation liability, and needed to know if there were a large enough market for such a plan. The DATA BASE was able to compile the needed information.

How To Obtain Information

Access to the DATA BASE can be accomplished in several ways. First, NASUA and NAAAA have published and will continue to anticipate and publish, the kinds of reports which potential users of the DATA BASE may want. In addition, anyone may contact the DATA BASE by using its toll free number: (800) 424-9126. A staff person will discuss your information request and compile a report tailored to your needs. For those with their own computer capability, machine-readable data sets are also available in a variety of formats.

What Do Services Cost?

The initial consultation to discuss how the DATA BASE can meet your information needs is free. After that, a $45.00 per hour charge is made for staff time involved in date retrieval, analysis and write up.

The DATA BASE can provide a great deal more than just raw statistics. Customized services and presentation-quality products include: proprietary reports analyzed to your specifications, longitudinal analyses, market segmentation (by state, county, or other criteria), charts, tables, and maps.

The National Data Base on Aging represents a new and important resource for a wide variety of users. It is anticipated that the data will be particularly useful to State and Area Agencies on Aging in improving the effectiveness and efficiency of services for the growing older population.

This article was prepared by DATA BASE staff from the National Association of State Units on Aging and The National Association of Area Agencies on Aging.

Information Categories In the National Data Base on Aging

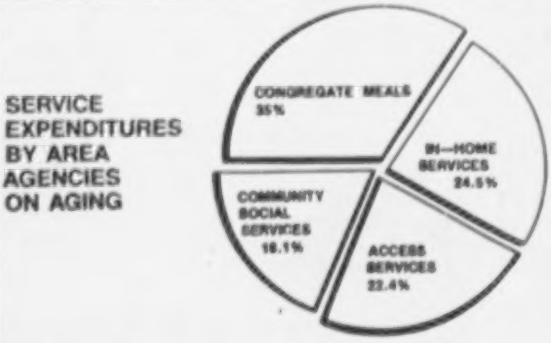
State Units on Aging:
- Executive Director Profile
- SUA Organization
- Staffing Profile/Turnover
- Advisory Council Make-Up and Functions
- Planning and Policy Approaches
- Intrastate Funding Formulas
- Funding Sources and Amounts
- Computer System Profile
- Program Accomplishments
- Management Initiatives
- Training/Professional Development Activities

Area Agencies on Aging:
- Executive Director Profile
- Staffing Profile/Turnover
- Advisory Council Make-up and Function
- AAA Organization
- Grants Management Procedures
- Planning and Policy Approaches
- Funding Sources and Amounts
- Computer System Profile
- Program Accomplishments
- Management Initiatives
- Training/Professional Development Activities

Service Provider Agency Grants and Contracts:
- Profile of each Provider
- Method of Reimbursement
- Priority Service and Clien Targeting
- Characteristics of Service Deliv ery Sites
- Sources and Amounts of Fundin

Clients and Services:
- Services Provided
- Expenditures and Units Provide by Service
- Numbers and Characteristics c Persons Served by Service

U.S. Census Statistics
- Total Population
- Elderly Population
- State, County, Planning, an Service Area Summaries



An example of the graphics that can be produced from the National Data Base on Aging

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUL 2 1986

'Honorable Thad Cochran
Chairman, Subcommittee on Energy,
Nuclear Proliferation, and
Government Processes
Committee on Governmental Affairs'
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for yours and Senator Grassley's letter of June 4 inviting our comments as a follow-up to your joint hearing on Statistical Policy in an Aging America.

Key VA officials attended that hearing and have been involved in the important coordination efforts to date regarding data collection and research highlighted at the hearing.

The VA, of course, is keenly interested in the area of aging-related statistics, particularly as regards the so-called aging veteran. We applaud the initiative of the National Institute on Aging and the Bureau of the Census to develop mechanisms to coordinate data collection and research in this area to meet Federal agencies' respective needs in a cost-efficient way.

While the VA already collects and analyzes some demographic and socio-economic data on aging veterans, we foresee additional data requirements that might be met through collaborative efforts. These include needs for epidemiological, demographic, and economic data. We welcome the prospect that this initiative to foster federal sharing of information-gathering and related policy planning may help meet these needs.

We look forward to continued progress on this initiative and intend to work toward it with the lead agencies. A similar letter has been sent to Senator Grassley.

Sincerely,

THOMAS K. TURNAGE
Administrator

INVENTORY OF DATA SETS RELATED TO THE HEALTH OF THE ELDERLY

Panel on Statistics for an Aging Population
Committee on National Statistics
Commission on Behavioral and Social Sciences and Education
National Research Council

Washington, DC 1986

NOTICE: The project that is the subject of this report was approved by the Governing Board of the National Research Council, whose members are drawn from the councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The members of the committee responsible for the report were chosen for their special competences and with regard for appropriate balance.

This report has been reviewed by a group other than the authors according to procedures approved by a Report Review Committee consisting of members of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

The National Research Council was established by the National Academy of Sciences in 1916 to associate the broad community of science and technology with the Academy's purposes of furthering knowledge and of advising the federal government. The Council operates in accordance with general policies determined by the Academy under the authority of its congressional charter of 1863, which establishes the Academy as a private, nonprofit, self-governing membership corporation. The Council has become the principal operating agency of both the National Academy of Sciences and the National Academy of Engineering in the conduct of their services to the government, the public, and the scientific and engineering communities. It is administered jointly by both Academies and the Institute of Medicine. The National Academy of Engineering and the Institute of Medicine were established in 1964 and 1970, respectively, under the charter of the National Academy of Sciences.

PANEL ON STATISTICS FOR AN AGING POPULATION

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PREFACE

The graying of the U.S. population is a fundamental and far-reaching contemporary demographic shift. This trend will have profound consequences for society, the economy, and health care. Many issues will arise in the areas of health and medical care, income support and social security, work opportunities, and the quality of life. The Committee on National Statistics, recognizing that adequate statistical information will be needed to make policy decisions for the elderly on a sound factual basis, proposed a study of statistical problems in policy analysis for an aging population. The objectives of the study are to determine data needs for policy analysis for health and related issues for the aging population; to assess the adequacy of current data sources; to make recommendations to fill data gaps; and to synthesize the statistical methodology useful in policy analysis for the elderly and recommend a research agenda to extend this methodology.

Funding for the study was provided by a consortium of agencies including the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services, the Health Care Financing Administration, the National Institute on Aging, the National Institute of Mental Health, the Social Security Administration, the Veterans Administration, and the National Center for Health Statistics, which is serving as the contracting agency for the study.

The Panel on Statistics for an Aging Population was established to undertake the study. At its first meeting, the panel recognized the need for a compilation of descriptions of available data sets related to the health of the elderly. It was proposed that the panel develop such a compilation, since existing inventories are not up to date. Although compiling the inventory made major demands on staff time, the panel was convinced that the investment was worthwhile, since the inventory has provided background essential for the panel's work and, in addition, will be a valuable resource for schools of public health and for the research community concerned with the aging population. The National Institute on Aging provided additional funding for the inventory because of its potential value to researchers.

The seven federal agencies sponsoring the panel's activities provided major assistance in developing the inventory. Each agency appointed a representative to a task force, chaired by Joan Van Nostrand of the National Center for Health Statistics, to assist in the design of the inventory and in the collection of information on the data sets of their respective agencies. The representatives were Paul Gayer (Office of Assistant Secretary for Planning and Evaluation, Department of Health and Human Services), Joan Van Nostrand (National Center for Health Statistics), Judith Kasper (Health Care Financing Administration), Ronald Abeles (National Institute on Aging), David Larson (National Institute of Mental Health), Melinda Upp (Social Security Administration), and Phyllis Thorburn (Veterans Administration). Their efforts greatly facilitated the completion of the inventory.

Joan Van Nostrand and panel member Jeanne Griffith gave freely of their time to participate in early meetings with the staff to plan the inventory. These initial plans were reviewed by the agency task force and by the panel. These reviews improved the plans for the inventory and enhanced the relevance of the information collected.

The panel was fortunate to have Lillian Guralnick take on primary responsibility for developing the inventory. Few people possess her broad knowledge of health statistics programs, her ability to organize a complex task, and her quiet persistence in follow-up and problem resolution. Staff member Carolyn Rogers tracked down information on academic data archives related to aging and assisted in drafting part of the introduction. Dorothy Gilford, study director, not only found both staff and funding resources for the inventory but also offered assistance and helpful counsel throughout its preparation. The panel also wishes to thank the many persons who provided information for one or more inventory forms, especially Donald Fowles (Administration on Aging), Cynthia Taeuber (Bureau of the Census), and Dan Walden (National Center for Health Services Research and Technology Assessment).

Paula Lovas of the National Gerontology Resource Center of the American Association of Retired Persons and Rosalyn Leiderman of the National Academy of Sciences Library gave generously of their time to complete a search for data bases in the literature on aging. Christine McShane, editor of the Commission on Behavioral and Social Sciences and Education helped to design the format for presenting the data sets and to resolve editorial problems as they arose. Staff member Carlotta Molitor with inexhaustible patience compiled the disks for the data sets in the inventory, took charge of the flow of mail, the corrections, and the endless detail.

For the panel and myself, I would like to express appreciation to all of the people involved, especially to Lillian Guralnick, for their commitment, dedication, and efforts. We, and the many people concerned with aging, are indebted to them.

Sam Shapiro, Chair
Panel on Statistics for
an Aging Population

INTRODUCTION

SCOPE OF THE INVENTORY

This inventory was prepared as part of the background for the work of the Panel on Statistics for an Aging Population. The first step in creating the inventory was to establish criteria for inclusion of a data set in the inventory. The panel agreed that a data system would be included if it met the following specifications:

(1) It comprises a periodic or a continuous national collection of information related to the health of the elderly population of the United States. (It may be part of a collection for the total population.) The data system may relate to the health of individuals, health care expenditures, services provided, or health care resources. It may be designed for individual data or for aggregate data, such as data for states or institutions.

(2) It contains one-time or subnational studies of seminal importance.

(3) It contains current data or the most recent available for a particular topic.

(4) It provides basic demographic data.

(5) It is available for further analysis, even though there may be some restrictions on use of the data.

The panel construed the health of the elderly broadly, as related to a way of life, rather than to physical condition alone. Housing, income, and availability and access to medical care and other life-support services were all seen as appropriate subjects related to health. The requirement that the data sets included in the inventory be available for further analysis reduced the number of eligible studies sharply, excluding in particular those that were not relatively recent.

GENERATING THE INVENTORY

The panel reviewed inventories of either data for the elderly or health data in general and selected data sets that met the stated criteria. The inventories reviewed are:

Health Data Inventory, Fiscal Year 1983-1984. (U.S. Department of Health and Human Services, January 1984).

Health and Human Services Inventory on Data Projects and Systems, Fiscal Year 1985. (U.S. Department of Health and Human Services, 1986).

Inventory of Federal Statistical Programs Relating to Older Persons. (U.S. Department of Health, Education, and Welfare, Administration on Aging, 1979).

Inventory of Data Sources on the Functionally Limited Elderly. (U.S. Office of Management and Budget, Human Resources, Veterans, and Labor Special Studies Division, 1980).

National Statistics on Children, Youth, and Their Families: A Guide to Federal Data Programs. (Prepared for the Interagency Conference on Child and Family Statistics, National Institute of Child Health and Human Development, Bethesda, MD, 1984. Many of the programs described apply to all age groups.)

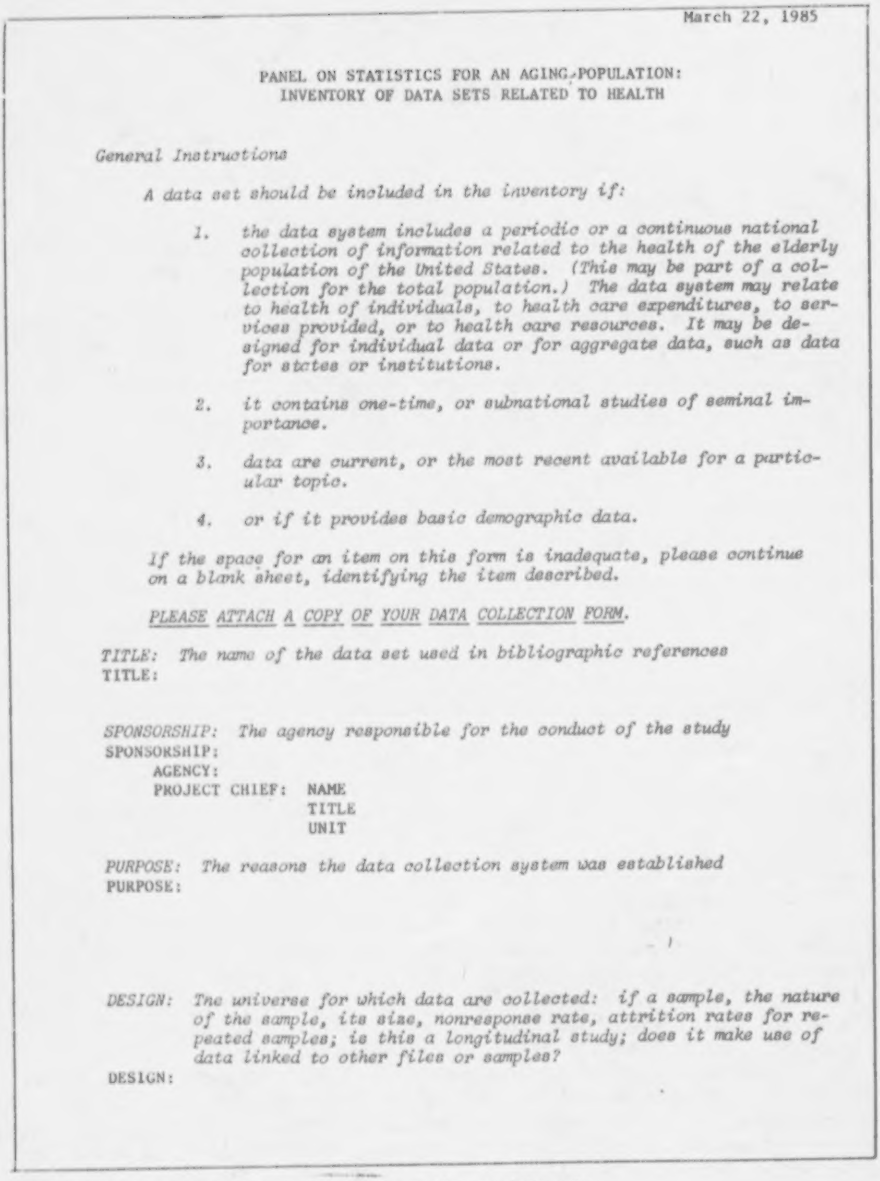
Inventory of U.S. Health Care Data Bases, 1976-83. (American Hospital Association and U.S.D.H.H.S. Health Resources and Services Administration. No publication date--1984?).

These sources do not exhaust the data on the elderly available in the United States, but do describe the major accessible studies.

A list of all apparently relevant data bases was culled from the six inventories listed. The list was separated into data sets collected by the sponsoring agencies and the remainder. The representatives of the sponsoring agencies took on responsibility for having the forms completed for all data sets listed for their respective organizations. In addition, they provided descriptions of studies too recent to be listed in any published inventory and major studies resulting from contracts or grants that had come to their attention.

A data collection form modeled after the one used in National Statistics on Children, Youth, and Their Families was adopted, with appropriate changes in format and in information to be collected (Figure 1).

For data sets collected by agencies other than sponsors, the contact person given in the inventory was called to ascertain the name of the most appropriate person to address for current information. The data collection form and a covering letter were sent to that person, requesting return of the completed form by a specific date. For many data requests, follow-up was necessary to elicit a response or to clarify or complete the information submitted. Generally, the completed forms from all sources were entered into a computer file with as little change as possible. It was not possible, however, to list all publications produced from some data sets; this is usually indicated in the description.



March 22, 1985

PANEL ON STATISTICS FOR AN AGING POPULATION:
INVENTORY OF DATA SETS RELATED TO HEALTH

General Instructions

A data set should be included in the inventory if:

1. *the data system includes a periodic or a continuous national collection of information related to the health of the elderly population of the United States. (This may be part of a collection for the total population.) The data system may relate to health of individuals, to health care expenditures, to services provided, or to health care resources. It may be designed for individual data or for aggregate data, such as data for states or institutions.*
2. *it contains one-time, or subnational studies of seminal importance.*
3. *data are current, or the most recent available for a particular topic.*
4. *or if it provides basic demographic data.*

If the space for an item on this form is inadequate, please continue on a blank sheet, identifying the item described.

PLEASE ATTACH A COPY OF YOUR DATA COLLECTION FORM.

TITLE: The name of the data set used in bibliographic references
TITLE:

SPONSORSHIP: The agency responsible for the conduct of the study
SPONSORSHIP:
AGENCY:
PROJECT CHIEF: NAME
TITLE
UNIT

PURPOSE: The reasons the data collection system was established
PURPOSE:

DESIGN: The universe for which data are collected: if a sample, the nature of the sample, its size, nonresponse rate, attrition rates for repeated samples; is this a longitudinal study; does it make use of data linked to other files or samples?
DESIGN:

FIGURE 1 Form used to collect information on data sets.

(2) TITLE:

CONTENT: Describe briefly the nature of information collected. If there are variations for different years or collection cycles, what are they?

CONTENT:

YEARS OF DATA COLLECTION: Describe the periodicity of the study, or list the individual years for which the study has been completed, the years now budgeted and planned, and expected release dates for current data collections.

YEARS OF DATA COLLECTION:

PUBLICATIONS: List major publications, or reference a list of publications.

PUBLICATIONS:

AVAILABILITY OF UNPUBLISHED DATA: Indicate whether data are available as unpublished tabulations or on public use data tapes, for what years, and how unpublished data can be obtained.

AVAILABILITY OF UNPUBLISHED DATA:

Are any of your data tapes in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, Ann Arbor, Michigan? Specify.

CONTACT: The person who can provide information about the data set; answer questions about published and unpublished data; and can refer the inquirer to technical staff, if necessary.

CONTACT: NAME
TELEPHONE NUMBER

TITLE:

Types of Data Collected

The categories are intended to show the content area of the data system, but not necessarily every item included in the data collection. Enter YES or NO for each item.

	Data File	Public Use Tape
DEMOGRAPHIC DATA		
Educational level	____	____
Race	____	____
Ethnicity	____	____
Sex	____	____
Marital status	____	____
Migration or mobility	____	____
VITAL STATISTICS		
Natality	____	____
Mortality	____	____
Marriage	____	____
Divorce	____	____
HOUSING		
Type of dwelling 1/	____	____
No. of persons in household	____	____
Relationship of persons in household	____	____
INCOME AND WEALTH		
Labor force participation	____	____
Total income	____	____
Sources of income	____	____
Net assets	____	____
HEALTH RESOURCES		
General hospitals	____	____
Private psychiatric hospitals	____	____
Public mental health hospitals	____	____
Nursing homes	____	____
Other institutional resources	____	____
Community-based resources	____	____
Health professions	____	____
Other professional resources	____	____
HEALTH EXPENSES		
Costs of care	____	____
Out-of-pocket costs	____	____
Medicare	____	____
Medicaid	____	____
State expenditures	____	____
Private insurance	____	____

	Data File	Public Use Tape
HEALTH		
Acute and chronic conditions 2/	____	____
Disability days	____	____
Chronic limitations:		
of activity	____	____
of mobility	____	____
Impairments	____	____
Usual activity status 3/	____	____
ALCOHOL, DRUG ABUSE AND MENTAL HEALTH		
Cognitive impairment scale	____	____
Behavior problems	____	____
Depression	____	____
Alcohol use	____	____
Drug abuse	____	____
CHANGES IN:		
Morbidity	____	____
Functional limitations	____	____
Self-perceived health	____	____
FUNCTIONAL LEVELS		
Social interaction 4/	____	____
Activities of daily living 5/	____	____
Instrumental activities of daily living 6/	____	____
HEALTH CARE UTILIZATION 7/		
General hospital services	____	____
Nursing home services	____	____
Home health care	____	____
Rehabilitation	____	____
Mental health hospitalization	____	____
Mental health outpatient services	____	____
Alcohol and drug abuse centers	____	____
Physician services/visits	____	____
Dental services/visits	____	____
Prescription drugs	____	____
Other	____	____
SOCIAL SERVICES 8/	____	____
OTHER BROAD CATEGORY FOR SAMPLING UNIT		
Specify: ________________	____	____
________________	____	____

---

1. House, apartment, boarding home, residential treatment centers, etc.
2. Includes diagnostic data
3. Normal daily activity: working, keeping house, retired, other
4. Social interaction includes contacts with friends, relatives, participation in group activities, including religious activities
5. Activities of daily living include ability to bathe oneself, dress oneself, etc.
6. Instrumental activities of daily living are defined as shopping, household chores, managing money, etc.
7. Utilization covers length of stay, number of discharges, days of care, number of visits
8. Includes domestic and transportation services, meals-on-wheels, day care, respite care, case management, etc.

(4)

TITLE:

Selected Items in Data Set

SIZE OF SAMPLE: Enter the number and the nonresponse rate for each age group. Enter NA (not available) where that is the case.

SIZE OF SAMPLE *(or universe, if the data set is not sampled):*

Age	Number in Sample	Nonresponse Rate
Total		
under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS: Enter YES if available, NA (not available) if that is the case.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS:

Item	Data File	Public Use Tape
Date of birth		
Social Security Number		
Veteran Status		

	Data File	Public Use Tape	Published Tables
Geographic data:			
Largest unit (Specify)			
Smallest unit (Specify)			
Age classes:			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other (Specify)			

Return this form and the data collection form to:

Dorothy M. Gilford, JH850
National Academy of Sciences
2101 Constitution Avenue, N.W.
Washington, D.C. 20418

Attention: Miss Lillian Guralnick

If you have any questions, please call Miss Guralnick at 202-484-1342, or 202-334-3010.

Letters were also sent to the directors of university gerontology study centers supported by grants from the Administration on Aging. A few responses were received to the effect that their studies did not meet the criteria; in one case, a useful data base was reported.

The National Technical Information Service in the U.S. Department of Commerce maintains an abstract file of all reports on research that are federally funded and deposited with their agency. The file was searched through the Dialog Information Retrieval Service for studies on the health of the elderly for reports published during the period 1965-1985. The search produced abstracts of an impressive list of reports and suggested inquiries for some additional data bases.

The area of research funded by nonfederal organizations was largely unexplored. The studies with nonfederal sponsorship listed in the inventory are those well known in the health literature.

The inventory will be added to the National Archive of Computerized Data on Aging maintained at the University of Michigan, where it will be updated periodically with support from the National Institute on Aging. Information on publicly available data sets not in this inventory that could be added should be sent to:

The Inter-University Consortium for Political and Social Research
P.O. Box 1248
Ann Arbor, MI 48106

GUIDE TO USE OF THE INVENTORY

The key to the inventory is the Summary Table (pages 18-29), which lists in alphabetical order the sponsors of the data sets followed by the data set titles. For data sets sponsored by more than one agency or when the supporting and contracting agencies differ, the names of all the participating organizations appear with appropriate cross-references. The Summary Table indicates the types of data collected with asterisks; when more than half the detailed items on the data collection form were checked, two asterisks are entered in the Summary Table.

The Summary Table can be used to locate the description of a known study, or to find the titles of all studies listed under the different types of data collected. Further information concerning a data set may be found in the narrative description provided on the individual forms.

In addition to the data set descriptions, the inventory includes a final section describing selected resources for additional data. The volume concludes with an index of data sets.

SOURCES OF DATA SETS

Some of the major federal and academic sources of data sets are described below, followed by information on relevant bibliographic services.

FEDERAL DATA SOURCES

Most health data are collected and made available by a few federal agencies. Some important sources of data on health and health-related topics for the elderly are described below.

Department of Health and Human Services (DHHS)

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation maintains the Evaluation Documentation Center. The Center makes the following services and materials available: a library of all DHHS final evaluation reports and executive summaries; compendium of DHHS evaluation studies, both completed and in progress; and abstracts of evaluation studies sorted by subject, program, sponsor, and dates. Information can be obtained from:

Health and Human Services Evaluation Documentation Center
Room 436G Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
(202) 245-7155

National Center for Health Statistics

The National Center for Health Statistics is one of the major federal statistical agencies. It operates a diverse survey and inventory program with legislative authorization to collect statistics on:

- The extent and nature of illness and disability of the population of the United States, including life expectancy, maternal morbidity, and mortality;
- The impact of illness and disability of the population on the economy of the United States and on other aspects of the well-being of its population;
- Environmental, social, and other health hazards;
- Determinants of health;
- Health resources, including health professionals by specialty and type of practice, and the supply of services by hospitals, extended care facilities, home health agencies, and other health institutions;
- Utilization of health care, including ambulatory health services, the services of hospitals, extended care facilities, home health agencies, and other institutions;
- Health care costs and financing; and
- Family formation, growth, and dissolution.

The Center's own data collection staff is very small. It collects most of its data through interagency agreements with the U.S. Bureau of the Census or through contracts with nonfederal organizations.
Its major data collection programs are:

Vital Statistics: births, deaths, marriages, and divorces
National Survey of Family Growth
National Health Interview Survey
National Medicare Care Utilization and Expenditure Survey
National Health and Nutrition Examination Survey
National Hospital Discharge Survey
National Ambulatory Medical Care Survey
National Nursing Home Survey
National Master Facility Inventory

These are described briefly in NCHS Data Systems of the National Center for Health Statistics, (Series 1, No. 16, December 1981), which also carries a description of the publication series (a series is used to publish data from a particular survey). The Center releases an annual Catalog of Publications of the National Center for Health Statistics. The Center also releases annually a Catalog of Public Use Data Tapes from the National Center for Health Statistics. The majority of these data tapes are now sold by the National Technical Information Service.

Requests for publications and information or inquiries concerning data tapes, special tabulations, and other assistance should be directed to:

Scientific and Technical Branch
National Center for Health Statistics
Public Health Service
Hyattsville, MD 20782

Social Security Administration

Various statistical data systems, containing both administrative and survey data, have been developed by the Office of Research, Statistics, and International Policy (ORSIP) of the Social Security Administration (SSA). Some of the data systems have been included in the inventory. All of the ORSIP data systems are described in the ORSIP Publications Catalog, 1986, Social Security Administration, Office of Policy, Office of Research, Statistics, and International Policy (SSA Publications No. 13-11925). A number of the files are designed for public use, but several are restricted and released only under certain legally defined conditions of privacy and confidentiality. In some cases, files are not available to the public even on a restricted basis. However, tabulations from such files may be obtained on a cost-reimbursable basis from SSA, provided they satisfy ORSIP disclosure guidelines.

General questions relating to the availability of data from restricted ORSIP files should be addressed to:

Confidentiality Policy Project, Room 912
Office of Research, Statistics, and International Policy (ORSIP)
Office of Policy
Social Security Administration
1875 Connecticut Avenue, NW
Washington, DC 20009
(202) 673-6024

Health Care Financing Administration

The Health Care Financing Administration (HCFA) is the federal program responsible for the overall administration of the Medicare and Medicaid programs. The Medicare program covers hospital, physicians, and related services chiefly for persons 65 years of age and older, while Medicaid is designed to serve the low-income population as defined by each state.

The process of administering the Medicare program gives rise to a complex system of files to identify insured persons, eligible providers of care, services used, payments to providers, and copayments and premiums paid by the insured. The files and their contents are completely described in the Medicare Statistical Files Manual, Bureau of Data Management and Strategy (BDMS), HCFA, September 1983. With the exception of public use files, HCFA data are confidential in accordance with the Privacy Act of 1974 (P.L. 93-579). Data are released only to contractors and grantees and other researchers in special cases.

The chief activity of HCFA is the administration of its program. Research is conducted mainly by the Office of Research and Demonstrations (ORD) and through grants and contracts. Each grant and contract supported by HCFA produces a final report that is placed with the National Technical Information Service (NTIS). In addition, the ORD and the BDMS publish an extensive series of reports providing program data and research findings. The Health Care Financing Review is a quarterly journal focusing on research, demonstration, and statistical findings in the area of health care financing. It is available by subscription from HCFA's Office of Research and Demonstrations.

Brief reports of program data are published in Health Care Financing Notes and more complete reports in the Medicare Program Statistics Series. Reports from all HCFA-funded extramural projects are available from NTIS. Selected reports are published in the Health Care Financing Grants and Contracts Reports series. A complete list of publications can be obtained from:

Publications and Information Resources Office
Oak Meadows Building
6325 Security Boulevard
Baltimore, MD 21207

Bureau of the Census

The Census Bureau is a major source of data and statistics on the population of the United States. Data published by age groups are based on decennial censuses and are used in planning and analysis concerning the elderly. Data from sample surveys such as the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP) are also useful in studying the elderly population.

A comprehensive guide to materials and reports published by the Census Bureau is contained in the publication Bureau of the Census Catalog: 1984. This catalog describes all products (reports, machine-readable files, microfiche, and maps) issued from January 1980 through December 1983. It also abstracts a few key reference publications issued before 1980 and includes a list of titles of all machine-readable data files, regardless of date. Chapters deal with one subject, e.g., population, and cover most data, although a special section combines all references from the 1980 Census of Population and Housing.

The population chapter contains socioeconomic data derived from the Census of Population and sample surveys. The following series of reports are based on the Current Population Survey:

P-20 Population Characteristics
P-23 Special Studies
P-27 Farm Population
P-60 Consumer Income

Several other data user guides are available. The Monthly Product Announcement updates the bibliographic references in the catalog. A monthly newsletter, Data Users News, informs data users about new Census Bureau products, census and survey plans, and other program developments. The Directory of Data Files contains abstracts that describe all Census Bureau data files (summary statistics, microdata and geographic reference data) and software issued through December 1983. Of particular interest is the Guide Book to 1980 Census Data on the Elderly.

A reference guide to the CPS lists reports by subject area, including sections on the elderly, income, and projections. The guide, updated annually, is: Current Population Reports, Series P-23, No. 109, Subject Index to Current Population Reports: December 1980, U.S. Government Printing Office, Washington, DC, 1981.

Data from SIPP are published in a working paper series as well as in quarterly reports in the Current Population Reports, Series P-70. To order data products, contact:

Data User Services Division
Customer Services
Bureau of the Census
Washington, DC 20233
(301) 763-4100

The Bureau has established a central focus for data on the older population under Cynthia M. Taeuber (301-763-7948). The goals of that office are to:

(1) Develop statistics on the older population that will meet the data needs of the research and policy-making community with quality data.
(2) Become a focal point for agencies inside and outside the government for shared interests in statistics on aging through cooperative programs.
(3) Work especially closely with agencies inside and outside the government that share Census Bureau interests.

Among the reports on aging prepared at the Bureau are:

U.S. Bureau of the Census, Jacob S. Siegel and Maria Davidson, Current Population Reports, Series P-23, No. 138, Demographic and Socioeconomic Aspects of Aging in the United States, U.S. Government Printing Office, Washington, DC, 1984.

U.S. Bureau of the Census, Cynthia M. Taeuber, Current Population Reports, Series P-23, No. 128, America in Transition: An Aging Society, U.S. Government Printing Office, Washington, DC, 1983.

Other federal organizations collect data specifically directed to their mission. The National Center for Health Services Research, the Administration on Aging, and the National Institute on Aging all produce information valuable to the study of health needs and services for the elderly population, as illustrated by the projects undertaken by these agencies that are listed in the inventory.

UNIVERSITY DATA SOURCES

Several universities have become specialized repositories for information related to the elderly, as well as in research in the field. The major centers are at the Duke University Medical Center, Brown University, and the University of Michigan.

Duke University Medical Center

The Center for the Study of Aging and Human Development at Duke was created in 1955 to serve as an all-university research facility. As such it has pioneered and continues to conduct research in multidisciplinary longitudinal studies of aging, behavioral and socioeconomic studies, life transitions (particularly retirement), basic biomedical topics, clinical studies, and policy studies.

The Center's research and training in the service of older adults includes the translation and dissemination of information to research investigators, practitioners, and the general public. The Division of Geriatrics coordinates advanced clinical training in medicine, family medicine, psychiatry, and other disciplines. In addition, the Center's Geriatric Evaluation and Treatment Clinic offers service to older persons and their families. Inquiries concerning the Center's research program should be addressed to:

Harvey Jay Cohen, M.D., Director
Center for the Study of Aging and Human Development
Box 3003
Duke University Medical Center
Durham, NC 27710

The Data Archive for Aging and Adult Development (DAAAD), established in 1976, provides research resources and support services for the study of aging and the life cycle from a social science perspective. Major resources are:

KWIC--a comprehensive index of training materials and related publications in gerontology and geriatrics.
DATA ARCHIVE--data sets, documentation, and consultation for research in adult development and aging, with emphasis on longitudinal studies and computer/statistical support.

Major activities include the identification, processing, and distribution of social surveys related to aging and life cycle research as well as the development of technical reports and measurement manuals. The DAAAD Reference Guide describes the current data holdings; DAAAD can distribute data tapes with documentation to interested users and also provides consultation services. Address inquiries concerning data to:

Linda K. George, Director, Data Archive
Box 3003
Duke University Medical Center
Durham, NC 27710
(919) 684-3204

Several pioneering research studies conducted by the Center include: Durham Older American Resources and Services (OARS) Community Survey, Durham OARS Institutional Survey, Second Duke Longitudinal Study (SDLS), and the Duke Work and Retirement Study. The development of the OARS methodology has subsequently led to numerous major studies of the well-being of older people. The Data Archive also contains national studies related to aging and health issues which are referenced elsewhere in the inventory. Publications of the Center are:

Center Report
Advances in Research
DAAAD Reference Guide

Brown University

The Brown University Data Archive for Use in Long-Term Care Policy Analysis includes data sets describing the needs of populations in terms of their health status, changes in health during given periods of time, and the impact of services. The aim of the center is to contribute to policy research in the field of aging and long-term care by developing a unique archive of information and testing its utility in selected policy analyses derived from evaluations of system performance.

The data archive consists of data from the following sources: (1) longitudinal and epidemiologic studies of chronic illness, (2) experimental studies of health services, (3) methodologic studies involving measurement and assessment of physical, psychological, and social function, (4) studies of effectiveness of multidisciplinary health care and long-term care services, (5) studies of efficacy of service and its impact in terms of change in health status over time, (6) studies of need, and (7) studies of utilization and cost of services. A brief description of current major holdings in the data archive follows.

1. Effects of Continued Care: A Study of Chronic Illness in the Home--to study the effectiveness of a treatment program in maintaining or improving the physical, psychological, and social well-being of patients as measured by function and to evaluate the impact of health services and patients' progress following discharge from a hospital rehabilitation program. Dates: 1963-1967, Cleveland, Ohio.
2. Chance for Change: Implications of a Chronic Disease Module Study--to evaluate the effects of an interdisciplinary team approach to long-term health care using a new type of health assistant. It was hypothesized that those who received module care would maintain function better than those who did not receive such service. Research findings from this study are applicable to decision making on financing and quality assurance in long-term care. Dates: 1973-1975, Michigan.
3. Bryn Mawr Rehabilitation Center Study--a study of responses of chronically ill patients to hospital rehabilitation care. Dates: 1974-1979.
4. Highland View Hospital Study--an observational study over a 10-year period of responses of chronically ill patients to hospital rehabilitation care. Dates: 1960-1970, Cleveland, Ohio.
5. Effects and Costs of Day Care and Homemaker Services for the Chronically Ill: A Randomized Experiment--to examine the differential impact of geriatric day care and homemaker services on the degree to which

an elderly patient can maintain independence in physical functioning without being institutionalized. Dates: 1975-1977, 6 sites in various locations in the United States.

6. The Health Care Needs of the Elderly and Disabled in Massachusetts--to estimate the number of persons in Massachusetts not currently in long-term care facilities who require placement in a nursing home as well as the number of persons with current needs for long-term home-based health and support services. Dates: 1974-1975, Massachusetts.

7. An Evaluation of a Day Hospital Service in Rehabilitation Medicine--to establish a separate day hospital service within an acute care public hospital for patients ordinarily admitted to the hospital for a continuous period of treatment and to evaluate the day hospital as a cost-effective alternative to intensive inpatient care. Dates: 1978-1980, Bronx, New York.

8. The Development of a Long-Term Care Information System--pilot study, to develop and demonstrate a method whose use would aid in the appropriate referral of individuals to long-term care services, and to provide a mechanism for translating assessment information into presumptive service needs. Dates: 1978-1979, Michigan.

9. Community-Based Long-Term Care and Mortality: Preliminary Findings of Georgia's Alternative Health Services Project--to test the cost-effectiveness of a comprehensive system of community-based long-term care services offered to elderly Medicaid recipients. Dates: 1976-1980, 17 Georgia counties.

Data archive development is an ongoing activity. Studies in the archive are selected according to their importance for policy research. Additional studies in the archive include: the U.S. General Accounting Office Survey in Cleveland, the Triage Study, An Approach to the Assessment of Long-Term Care, the Randomized Trial of a New Team Approach to Home Care for the Terminally Ill, and longitudinal studies of recovery over time for stroke and hip fractures at Benjamin Rose Hospital in Cleveland. Data in the archive are available in machine-readable files. Detailed documentation of these studies, including research design, sampling, data collection methods, analysis, results, conclusions, and recommendations are available from the data archive of the Southeastern New England Long-Term Care Gerontology Center. For information, contact:

Sidney Katz, M.D., Director
Southeastern New England Long-Term Care Gerontology Center
Brown University--Box G
Brown and Meeting Streets
Providence, RI 02912
(401) 863-3821

University of Michigan

The National Archive of Computerized Data on Aging (NACDA) is a project currently sponsored by the National Institute on Aging and conducted by the Inter-university Consortium for Political and Social Research (ICPSR) in collaboration with the University of Michigan Institute of Gerontology. Harold Johnson, Dean of the School of Social Work at the University of

Michigan, and Jerome Clubb, Executive Director of the Inter-university Consortium, are codirectors of the project.

NACDA's mission is to facilitate quantitative research in the field of aging by providing data collections in readily usable formats to the widest possible audience of researchers. Data collections are distributed on magnetic tape without charge to individuals affiliated with the 300 colleges and universities that are members of ICPSR. Researchers not located at ICPSR member institutions are assessed a modest charge for access, based on the size of the data collection requested.

Requests for data should be addressed to:

National Archive of Computerized Data on Aging
P.O. Box 1248
Ann Arbor, MI 48106

(Those affiliated with colleges and universities holding membership in the ICPSR should submit requests through their ICPSR "Official Representative.") The project staff may be reached by telephone (313) 764-5199 (Michael Traugott) or (313) 763-5010 (Patricia Green).

A catalog is available from the National Archive of Computerized Data on Aging that includes descriptions of the data collections relevant to research on aging. The ICPSR Guide to Resources and Services contains a complete listing of the archive's data collections. Further information regarding ICPSR and its membership, policies, and services can be obtained by contacting the ICPSR staff at (313) 764-2570 or by writing:

ICPSR
P.O. Box 1248
Ann Arbor, MI 48106

BIBLIOGRAPHIC SERVICES

American Association of Retired Persons

The National Gerontology Resource Center maintained by the American Association of Retired Persons (AARP) is designed to provide research and information support to the staff of AARP, as well as to other aging-related organizations, academic institutions, and government agencies. Library materials may be borrowed through interlibrary loans. Requests should be sent to:

AARP
National Gerontology Resource Center
1909 K Street, NW
Washington, DC 20049
Attn: Interlibrary Loan
(202) 728-4883

The Resource Center produces the Ageline computerized bibliographic database, which is publicly available through Bibliographic Retrieval Services (BRS). The data base contains citations with abstracts of the literature of gerontology, primarily since 1978. Journal coverage includes gerontological, social science, health, business, and news periodicals; books, government documents, project reports, conference papers, and dissertations are also included. For information on accessing Ageline through the BRS service, contact:

BRS Customer Service
1200 Route 7
Latham, NY 12110
(800) 933-4704
(518) 783-1161 in New York State

National Technical Information Service

The National Technical Information Service (NTIS), Department of Commerce, provides a database consisting of government-sponsored research, development, and engineering plus analyses prepared by federal agencies, and their contractors or grantees. State and local government agencies are now beginning to contribute their reports to the NTIS file. The Administration on Aging and the Health Care Financing Administration routinely send copies of all reports prepared in completion of a grant or contract to NTIS, but this may not be true for every federal agency. The NTIS is also a repository for data tapes for many federal data collection agencies. When the data tapes for any study described in the inventory have been placed on file at NTIS, it has been noted in the description.

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22151
(703) 487-4600

SUMMARY TABLE: DATA BASE CONTENT BY SPONSOR AND TITLE OF DATA SET

SPONSOR AND TITLE OF DATA SET

ADMINISTRATION ON AGING (AoA), DHHS
Alternate Paths to Long-Term Care
Longitudinal Evaluation of Nutrition Services for the Elderly
National Data Base on Aging
National Long-Term Care Channeling Demonstration Program (see ASPE)
National Survey of the Aged, 1975 (with Social Security Administration)
Nationwide Study of Domiciliary Care: Domiciliary Care Clients and the
  Facilities in Which They Reside
Nationwide Study of Domiciliary Care: National Survey of Domiciliary Care
State Long-Term Care Ombudsman Report

AMERICAN HOSPITAL ASSOCIATION (AHA)
Annual Survey of Hospitals
National Hospital Panel Survey
Survey of Medical Rehabilitation Hospitals and Units, 1983
Survey of Medical Staff Organization, 1982

ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE), DHHS
National Long-Term Care Channeling Demonstration Program (with HCFA and AoA)
National Survey of Long-Term Care/National Survey of Caregivers (with HCFA)
Panel Study of Income Dynamics (PSID) (with NSF)
Survey of Institutionalized Persons, 1976 (with Bureau of the Census)

BUREAU OF THE CENSUS, DEPARTMENT OF COMMERCE
County and City Data Book
Current Population Survey (CPS) (with Bureau of Labor Statistics)
Decennial Census of Population and Housing
National Longitudinal Mortality Study (see NCHS)
State and Metropolitan Area Data Book
Survey of Income and Program Participation (SIPP)
Survey of Institutionalized Persons, 1976 (see ASPE)

BUREAU OF LABOR STATISTICS (BLS), DEPARTMENT OF LABOR
Consumer Expenditure Survey
Consumer Price Index (CPI)
Current Population Survey (CPS) (see Bureau of the Census)
Industry Wage Survey: Hospitals
Industry Wage Survey: Nursing Homes

Page	Demographic Data	Vital Statistics	Housing	Income & Wealth	Social Services	Health Resources	Health Expenses	Health	Alcohol, Drug Abuse, Mental Health	Changes in Health Status	Functional Levels	Health Care Utilization	Other broad categories
31	**							*			**	*	
35	**		*	*	*			*	**		**	*	**
39	*		*	*		*	*					*	**
42	**	*	**	**			*	*			**	*	
45	**		*	*		*	*	*	*	**	**	*	
48	**	*	*	*		*	*	**	*	**	**	*	
51													
55						**	**					**	
58				*		*						*	
61						**	**	**				*	
64	*					*						*	
67	**	**	**	**	*	**	**	**	**	**	**	**	
71	**	**	**	**			**	**	*		**	**	
74	**	**	**	**				**		**	**	*	
78	**			**			**	**			**	*	
82	**	**	**	*		*	*						
85	**	*	**	*				*					*
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92	**	**	**	*		**	**					*	
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100	**		**	**			**						
103													*
106	*					*							
109	*					*							

** Major category(ies) in data set
* Other category in data set
For Other Broad Categories, see individual data set description

CASE WESTERN RESERVE UNIVERSITY
GAO Cleveland Follow-up (see Urban Institute)

CENTERS FOR DISEASE CONTROL (CDC), PHS, DHHS
Annual Tuberculosis Statistical Summary
National Immunization Survey--CPS Supplement
Report of Verified Case of Tuberculosis

CENTER FOR HEALTH ADMINISTRATION STUDIES, UNIVERSITY OF CHICAGO
Robert Wood Johnson Foundation
Community Hospital Program (CHP) Access Impact Evaluation Surveys, 1978-79, 1981
Municipal Health Services Program (MHSP) Evaluation (with HCFA)
National Survey of Access to Medical Care, 1982

COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES (CPHA)
CPHA Data Tapes

CONSUMER PRODUCT SAFETY COMMISSION
National Electronic Injury Surveillance System (NEISS)

DEPARTMENT OF AGRICULTURE (USDA)
Nationwide Food Consumption Survey, 1977-78

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)
American Housing Survey

DEPARTMENT OF LABOR
National Longitudinal Surveys of Labor Market Experience of Older Men (Parnes Survey) (with NSF)

DUKE UNIVERSITY, CENTER FOR THE STUDY OF AGING AND HUMAN DEVELOPMENT
Durham Older Americans Resources and Services (OARS) Community Survey

EMPLOYEE BENEFIT RESEARCH INSTITUTE
Survey of Pension and Retirement Plan Coverage, 1972, 1979, 1983

FOOD AND DRUG ADMINISTRATION (FDA)
Dietary Supplements Survey

GENERAL ACCOUNTING OFFICE (GAO)
Nursing Home Data by State, 1976-80

Page	Demographic Data	Vital Statistics	Housing	Income & Wealth	Social Services	Health Resources	Health Expenses	Health	Alcohol, Drug Abuse, Mental Health	Changes in Health Status	Functional Levels	Health Care Utilization	Other broad categories
112	*							*					**
115	*												*
118	*							*					**
121	**		**	**				*				*	
125	**		**	**			**	*				*	
129	**		**	**			*	*				*	
132	*	*				*		*					*
136	*												*
139	**		**	**									*
143	**	**	**	**									
147	**	**	*	**				*		*	**		
151	**	*	**	**	*	*	*	**	**	**	**	**	
155	**	*	**	**			*						*
159	**			*						*			*
162						*						*	

** Major category(ies) in data set
* Other category in data set
For Other Broad Categories, see individual data set description

HEALTH CARE FINANCING ADMINISTRATION (HCFA), DHHS

Bureau of Data Management and Strategy

Master Provider of Services File
Medicare Annual Summary: Person Summary File
Medicare Enrollment File
Medicare History Sample--1974 and Later
Medicare Part B (SMI) 5-percent Sample Bill Summary Record
Medicare Reimbursement by State and County
MEDPAR Public Use File

Office of Financial and Actuarial Analysis

Analysis of State Medicaid Program Characteristics
Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, Medicaid Program

Office of Research and Demonstrations

Linked Medicare Use--NCHS Mortality Statistics File
Medicaid Tape-to-Tape Project
Medigap
Municipal Health Services Program (MHSP) Evaluation (see Center for Health Administration Studies)
National Long-Term Care Channeling Demonstration Program (see ASPE)
National Medical Care Utilization and Expenditure Survey (NMCUES) 1980 (see NCHS)
1984 Long-Term Care Survey

INTERNAL REVENUE SERVICE (IRS), DEPARTMENT OF THE TREASURY

Estate/Personal Wealth File
Statistics of Income: Individual Income Tax Returns

ROBERT W. JOHNSON FOUNDATION

See Center for Health Administration Studies, University of Chicago

- Community Hospital Program (CHP) Access Impact Evaluation Surveys, 1978-79, 1981
- Municipal Health Services Program (MHSP) Evaluation (with HCFA)
- National Survey of Access to Medical Care, 1982

NATIONAL CANCER INSTITUTE (NCI), NIH, PHS, DHHS

Surveillance, Epidemiology, and End Results (SEER) Program

Page	Demographic Data	Vital Statistics	Housing	Income & Wealth	Social Services	Health Resources	Health Expenses	Health	Alcohol, Drug Abuse, Mental Health	Changes in Health Status	Functional Levels	Health Care Utilization	Other broad categories
165						**							
168	*						*					*	
171	*												
174	*	*					*	*		*		**	
178	*						*					*	
181	*						*					**	
184	*						*	*				*	
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190	*				*	*	*					**	
194	*	*					*					**	
197	*	*				**	**	*				**	
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206	*			*									**
210	*			**			*						
214	**	**						*					*

** Major category(ies) in data set

* Other category in data set

For Other Broad Categories, see individual data set description

NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT (NCHSR)

Hospital Cost and Utilization Project: National Sample of Hospitals_______
National Medical Care Expenditures Survey (NMCES), 1977-78 (with NCHS)_____
Outcomes of Nursing Home Admissions___________________________________

NATIONAL CENTER FOR HEALTH STATISTICS (NCHS), PHS, DHHS

Hispanic Health and Nutrition Examination Survey (HHANES)________________
Life Tables, Vital Statistics of the United States_____________________
Longitudinal Study of Aging (LSOA)______________________________________
National Ambulatory Medical Care Survey (NAMCS)__________________________
National Death Index (NDI)____
National Divorce Statistics____
National Health Interview Survey (NHIS): Core Questionnaire_____________
National Health Interview Survey: Data for the Study of Secular Change and Aging (with NIA)____
National Health Interview Survey: Supplement on Aging (SOA), 1984________
National Health Interview Survey: Supplements__________________________
National Health and Nutrition Examination Survey (NHANES I)_____________
NHANES I Epidemiologic Follow-up Study: Initial Follow-up, 1982-1984 (with NIA)____
NHANES II, Second National Health and Nutrition Examination Survey________
National Hospital Discharge Survey (NHDS)_______________________________
National Longitudinal Mortality Study (with NHLBI and Bureau of the Census)_
National Marriage Statistics____
National Master Facility Inventory (NMFI)_______________________________
National Medical Care Expenditures Survey, 1977-78 (NMCES) (see NCHSR)_____
National Medical Care Utilization and Expenditure Survey (NMCUES), 1980 (with HCFA)____
National Mortality Followback Surveys___________________________________
National Mortality Statistics File_____________________________________
National Natality Statistics____
National Nursing Home Survey (NNHS)_____________________________________

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI), NIH, PHS, DHHS

The Framingham Study____
Honolulu Heart Program____
National Longitudinal Mortality Study (see NCHS)_________________________

Page	Demographic Data	Vital Statistics	Housing	Income & Wealth	Social Services	Health Resources	Health Expenses	Health	Alcohol, Drug Abuse, Mental Health	Changes in Health Status	Functional Levels	Health Care Utilization	Other broad categories
218	*	*				*	**	*		*		*	
221	**	*	**	**			**	**				**	
226	*	**	*			*	**	**	*		*	*	
230	**		**	**				*	**			**	**
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276	**	*	**	**				*					
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283	*					**						*	
286	**		**	**			**	**				**	
290	**	**	**	**	*		**	*	*		*	**	
294	**	*						*					
297	**	*										*	
300	**	*	**				**	*	*	**	**	*	
304	**	**						**	*	**	**	*	
307	**	**	**	*				*	*	**	*	*	

** Major category(ies) in data set
* Other category in data set
For Other Broad Categories, see individual data set description

NATIONAL INSTITUTE ON AGING (NIA), NIH, PHS, DHHS
Baltimore Longitudinal Study of Aging
East Boston Study on the Natural History of Senile Dementia
Established Populations for Epidemiologic Studies of the Elderly (EPESE)
NHANES I Epidemiologic Follow-up Study: Initial Follow-up, 1982-1984 (see NCHS)
Survey of the Last Days of Life

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT
Study of Low Fertility Cohorts in the United States

NATIONAL INSTITUTE OF DENTAL RESEARCH (NIDR), NIH, PHS, DHHS
Epidemiologic Survey of Oral Health in Adults, 1985

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA), PHS, DHHS
National Alcoholism and Drug Abuse Program Inventory (NADAPI) (with National Institute on Alcohol Abuse and Alcoholism [NIAAA])

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH), PHS, DHHS
Annual Census of Patient Characteristics for State and County Mental Hospital Inpatient Services
Epidemiologic Catchment Area (ECA) Program Community Surveys
Health Demographic Profile System's Inventory of Small Area Social Indicators
Inventory of General Hospital Psychiatric Services
Inventory of Mental Health Organizations
Patient Surveys of Inpatient Mental Health Settings

NATIONAL OPINION RESEARCH CENTER (NORC)
General Social Surveys (see National Science Foundation)

NATIONAL SCIENCE FOUNDATION (NSF)
General Social Surveys
Panel Study of Income Dynamics (see ASPE)
Parnes Survey (see Department of Labor)

PUBLIC HEALTH FOUNDATION
ASTHO Reporting System

Page	Demographic Data	Vital Statistics	Housing	Income & Wealth	Social Services	Health Resources	Health Expenses	Health	Alcohol, Drug Abuse, Mental Health	Changes in Health Status	Functional Levels	Health Care Utilization	Other broad categories
310													
314	**	*	**	*		**		**	**	**	**	*	
317	**	**	**	*	*	**	*	**	**	**	**	**	
321	**	*		*	*	*	*	*		**	*	*	
324	**	**	**	*				*			**		
327	**		*	*				*				*	
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355	*	*			*	**	**	*	*			**	

** Major category(ies) in data set
* Other category in data set
For Other Broad Categories, see individual data set description

SOCIAL SECURITY ADMINISTRATION (SSA), DHHS
Continuous Work History Sample (CWHS)
1978 Survey of Disability and Work
1982 New Beneficiary Survey
1986 Survey of Supplemental Security Income (SSI) Recipients and the General Aged Population
National Survey of the Aged, 1975 (see AoA)
Retirement History Study
Supplemental Security Income Medicaid Institution Turnover (SSIMIT) Files
Yearly Continuous Disability History Sample (CDHS)

SURVEY RESEARCH CENTER, UNIVERSITY OF MICHIGAN
Survey of Consumer Finances (SCF)

UNIVERSITY OF KANSAS LONG-TERM CARE GERONTOLOGY CENTER
Kansas Comprehensive Assessment

URBAN INSTITUTE
Older Americans Resources and Services (OARS), Merged Data Set

VETERANS ADMINISTRATION (VA)
Annual Patient Census File
Hospital Based Home Care (HBHC) Information System
1979 National Survey of Veterans
Patient Treatment File
Survey of Aging Veterans, 1983
Survey of VA Long-Term Care Patients

Page	Demographic Data	Vital Statistics	Housing	Income & Wealth	Social Services	Health Resources	Health Expenses	Health	Alcohol, Drug Abuse, Mental Health	Changes in Health Status	Functional Levels	Health Care Utilization	Other broad categories
358	*	*											
361	**	**	**	**	*		**	**	**		**	**	
364	**	**	**	**				**			*		
367	**	**	**	**	*	*	**	*			**	*	
370	**	**	**	**			**	*		*	*	*	
374	*			*					*	*			
377	*			*				**					
380	**		**	**									
383	**	*	**		*			**	**	**	**	*	
387	**	*	**	**	*		*	**	**	**	**	**	
391	*	**						**	**	**			
394	*							*	**	*	**	*	
397	**	*		**			*	*	**			*	
400	*	**						**	**	**		*	
403	**	*	**	**			*	**	**	*	**	**	
406	*					*		**	**	*	**	*	

** Major category(ies) in data set
* Other category in data set
For Other Broad Categories, see individual data set description

277

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Alternate Paths to Long-Term Care**

CONTRACTOR: Hebrew Rehabilitation Center for the Aged

Project Director:
Sylvia Sherwood
Director of Social Gerontological Research
Hebrew Rehabilitation Center for the Aged
Boston, MA 02131

PURPOSE: To gain knowledge about comparative benefits and costs of alternate service modalities for long-term care of at-risk older persons and to gain knowledge regarding the choice by the elderly client of one particular modality rather than another.

DESIGN: Data were collected from four sources:

- Elderly clients
- Key members of client's informal support network
- Formal agencies, including state agencies
- Direct care providers

Sample selection methodology varied by modality. Data were gathered for 206 nursing home applicants, 175 senior center applicants, 103 geriatric day hospital applicants, and 77 domiciliary care applicants.

CONTENT: Data were gathered for sample of chronically ill and functionally impaired elderly applicants to four service modalities:

- Intermediate care facility nursing homes
- Geriatric day hospitals
- Domiciliary care facilities
- Senior center programs

Data covered reasons for choice of modality; demographic, health, functional, and support service characteristics; knowledge, attitudes, and access to long-term care options; services provided by chosen modality.

YEARS OF DATA COLLECTION: 1978

SPONSOR:	Administration on Aging (AoA), Department of Health and Human Services (DHHS)
TITLE:	**Alternate Paths to Long-Term Care**
PUBLICATIONS:	*Alternate Paths to Long Term Care*, Final Report to the Administration on Aging, prepared under DHHS/AoA Grant # 90-A-1666, by Sylvia Sherwood, and John N. Morris, and associates, Hebrew Rehabilitation Center for the Aged, Boston, June 1982.
AVAILABILITY OF UNPUBLISHED	For information about availability of data tapes, contact Claire Gutkin.
CONTACT:	Claire Gutkin Hebrew Rehabilitation Center for the Aged (617) 325-8000

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Alternate Paths to Long-Term Care**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
x		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Alternate Paths to Long-Term Care**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not available	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Not available		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74			

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Longitudinal Evaluation of Nutrition Services for the Elderly**

CONTRACTORS:
Kirschner Associates, Inc.
2425 Alamo Avenue, SE
Albuquerque, NM 87016

Opinion Research Corporation
North Harrison Street
Box 183
Princeton, NJ 08540

Project Directors: Richard W. Kirschner
Kirschner Associates, Inc.

Glenn E. Davis
Opinion Research Corporation

PURPOSE:

(1) Assess operation of nutrition programs operated under Title III of Older Americans Act.

(2) Assess impact of nutrition programs on diet and health of older participants.

DESIGN: Participant portion of study includes four universes of persons 60+ years old:

- Congregate meal site participants (n = 1,735)
- Neighbors of congregate meal site participants (n = 1,039)
- Home-delivered meal recipients (n = 415)
- Former congregate meal site particopants (n = 249)

A total of 3,438 personal interviews in 1982 were conducted among older people living near 70 meal sites across the country. The longitudinal aspect of the study refers to an attempt to interview over 1,700 respondents at 34 of these sites who had participated in a similar study in 1976-77. Only 720 of these respondents were successfully tracked and interviewed, including 450 who were program participants during the earlier study and 270 who were nonparticipating neighbors.

CONTENT: Major topics of participant portion of study include:

- Personal experience with nutrition program
- Personal evaluation of nutrition program
- Personal mobility (includes activities of daily living)
- Health
- Eating habits
- Psychological well-being
- Social life
- Income sufficiency
- Demographics
- 24-hour dietary recall
- Interviewer's observations

SPONSOR:	Administration on Aging (AoA), Department of Health and Human Services (DHHS)
TITLE:	**Longitudinal Evaluation of Nutrition Services for the Elderly**
YEARS OF DATA COLLECTION:	1982
PUBLICATIONS:	An Evaluation of the Nutrition Services for the Elderly, Kirschner Associates, Inc., and Opinion Research Corporation, May 1983. Volume I. Executive Summary Volume II. Analytic Report Volume III. Descriptive Report Volume IV. Appendices Volume V. Questionnaires Longitudinal Evaluation of the National Nutrition Program for the Elderly: Reports on First Wave Findings, Kirschner Associates, Inc., and Opinion Research Corporation, February 1979.
AVAILABILITY OF UNPUBLISHED DATA:	Data tapes are available in the collection of the National Archive of Computerized Data on Aging, P.O. Box 1248, Ann Arbor, MI 48106. Telephone (313) 763-5010; or through the Inter-university Consortium for Political and Social Research, at the same address.
CONTACT:	Richard W. Kirschner Kirschner Associates, Inc. (505) 243-1763 Glenn E. Davis Opinion Research Corporation (609) 924-5900

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Longitudinal Evaluation of Nutrition Services for the Elderly**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
		Sources of income
		Net assets
x		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
x		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Eating habits
x		Dietary recall

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Longitudinal Evaluation of Nutrition Services for the Elderly**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	3,438	
Under 65	411	
65-74	1,464	
75-84	1,551	
85+	12	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	National	National	National
Smallest unit			
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other: 60+	x	x	x

SPONSOR:	Administration on Aging (AoA), Department of Health and Human Services (DHHS)
TITLE:	**National Data Base on Aging**
CONTRACTOR:	National Association of Area Agencies on Aging/ National Association of State Units on Aging (NAAAA/NASUA)
	Project Directors: Pamela Larson, NAAAA Rob[illegible] Ficke, NASU[illegible] Suite 208 (West) 600 Maryland Avenue, SW Washington, DC 20024
PURPOSE:	The National Data Base on Aging is a voluntary annual survey that collects information at the national level about the network of state and area agency on aging programs.
DESIGN:	Initial questionnaires were mailed to all 57 state units and 666 area agencies in September 1981. State units are surveyed annually. Updates for area agencies are made from a systematic 1/3 sample in each subsequent year, with a 65% response rate in 1984.
CONTENT:	The data collection included questions on the staffing of the agencies, the types of funding used, and the characteristics of service providers, services provided, and service recipients.
YEARS OF DATA COLLECTION:	Annually since 1981.
PUBLICATIONS:	A Profile of State and Area Agencies on Aging, 1981. Staffing Patterns and Functions of State and Area Agencies, 1982. Funding Sources and Expenditure Patterns of State and Area Agencies, 1982. Services to Older Persons Supported by State and Area Agencies, 1982. Program Accomplishments of State Units on Aging, 1984. Management Accomplishments of State Units on Aging, 1984.
AVAILABILITY OF UNPUBLISHED DATA:	Data can be accessed by calling the National Data Base on Aging (800-424-9126). Staff will retrieve and format data according to individual requests. 1981 data tape (ICPSR 9036) is in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.
CONTACT:	Pamela Larson, NAAAA (202) 484-7520 Robert Ficke, NASUA (202) 484-7182

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **National Data Base on Aging**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
	x	Race
	x	Ethnicity
	x	Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
	x	No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
	x	Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
	x	Community-based resources
		Health professions
	x	Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
	x	State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
	x	Home health care/personal care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
		Agency expenditures
		Source of expenditures
		Personnel of state and area agencies

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **National Data Base on Aging**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable Data aggregated by state	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State	State	
Smallest unit	Area agency	Area agency	
Age classes (service recipients)			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other: 60-75 and 75+	x	x	

SPONSORS:	Administration on Aging (AoA) and the Social Security Administration (SSA), Department of Health and Human Services (DHHS)
TITLE:	**National Survey of the Aged, 1975** Project Director: Ethel Shanas Department of Sociology University of Illinois at Chicago Circle Box 4348 Chicago, IL 60680
PURPOSE:	To develop national estimates of the economic and social needs of old people in 1975.
DESIGN:	A national sample of 2,143 noninstitutionalized Americans was interviewed. Nonresponse rate, 21.4%. Study design is similar to national surveys of 1957 and 1962. The 1975 universe sampled was the total U.S. noninstitutionalized population aged 65 and over. The sample was a multistage area probability sample. Data were collected in 400 interviewing locations throughout the United States.
CONTENT:	The survey attempts to describe the aged population and indicate the degree of health, economic status, work status, familial support, and use of health services in that group.
YEARS OF DATA COLLECTION:	1975; previous studies were made in 1957 and 1962.
PUBLICATIONS:	Ethel Shanas with the assistance of Gloria Heinemann. 1982. *National Survey of the Aged 1975*. DHHS Pub. No. (OHDS) 83-20425. For 1962 survey, see: Shanas, E., Townsend, P., Wedderburn, D., Friis, H., Milhoj, P., and Stehower, J. 1968. *Old People in Three Industrial Societies*. New York: Atherton Press; London: Routledge and Kegan Paul. For 1957 survey, see: *The Health of Older People: A Social Survey*. 1962. Cambridge, MA: Harvard University Press.
AVAILABILITY OF UNPUBLISHED DATA:	Data tapes are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, Ann Arbor, MI: 1975 National Survey of the Aged (ICPSR 7945), 1962 National Survey of the Aged, 1957 National Survey of the Aged (ICPSR 7686).
CONTACT:	Patricia Green, Inter-university Consortium for Political and Social Research (313) 764-2570

SPONSORS: Administration on Aging (AoA) and the Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **National Survey of the Aged, 1975**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
	x	Marriage
		Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
	x	Sources of income
	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
	x	Medicare
	x	Medicaid
		State expenditures
	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
	x	of activity
	x	of mobility
	x	Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
	x	Social interaction
	x	Activities of daily living
	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
	x	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSORS: Administration on Aging (AoA) and Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **National Survey of the Aged, 1975**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	1975: Weighted Estimate of Respondents	1975: Weighted Estimate of Nonrespondents
Total	5,756	1,904
Under 65		
65-74	3,735	626
75-84	1,667	261
85+	352	41
Nonrepondents 65+		978

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit		U.S.	U.S.
Smallest unit			
Age classes			
Single years			
60-64			
65+		x	x
65-74, 75-84, 85+		x	x
Other			

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Nationwide Study of Domiciliary Care: Domiciliary Care Clients and the Facilities in Which They Reside**

CONTRACTOR: Hebrew Rehabilitation Center for the Aged

Project Director: Sylvia Sherwood
Director of Social Gerontological Research
Hebrew Rehabilitation Center for the Aged
Boston, MA 02131

PURPOSE: To examine the relationship between domiciliary care programs, policies, facilities, and client characteristics.

DESIGN: 680 aged persons were randomly selected from a random sample of 230 homes of various types in five states identified in purposive sample (Florida, Georgia, Illinois, Massachusetts, Michigan) and 208 aged persons were sampled in homes in Pennsylvania. Data were gathered on homes and on clients.

CONTENT: Client data includes demographics, residential history, health, physical functions, emotional and intellectual status, costs, and clinical judgments.

Data on homes include size, ownership, geography/neighborhood, client population characteristics, rules, services, costs, and provider characteristics.

YEARS OF DATA COLLECTION: 1980

PUBLICATIONS: Domiciliary Care Clients and the Facilities in Which They Reside, Final Report to the Administration on Aging, prepared under DHHS/AoA Grant # 90-A-1659, by Sylvia Sherwood, Vincent Morris, and Claire Gutkin of the Hebrew Rehabilitation Center for the Aged, Boston, December 1981.

Report on Administrative Structure of Domiciliary Care Programs Serving the Elderly in Six States, Sherwood, Morris, and Gutkin, December 1981.

AVAILABILITY OF UNPUBLISHED DATA: For information about availability of data tapes, contact Claire Gutkin.

CONTACT: Claire Gutkin
Hebrew Rehabilitation Center for the Aged
(617) 325-8000

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Nationwide Study of Domiciliary Care: Domiciliary Care Clients and the Facilities in Which They Reside**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
x		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
x		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
x		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Nationwide Study of Domiciliary Care: Domiciliary Care Clients and the Facilities in Which They Reside**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not available	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Not available		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR:	Administration on Aging (AoA), Department of Health and Human Services (DHHS)
TITLE:	**Nationwide Study of Domiciliary Care: National Survey of Domiciliary Care**
CONTRACTOR:	Hebrew Rehabilitation Center for the Aged Project Director: Sylvia Sherwood Director of Social Gerontological Research Hebrew Rehabilitation Center for the Aged Boston, MA 02131
PURPOSE:	To study (1) program organization and costs, (2) residents' characteristics, (3) facility characteristics, (4) Supplemental Security Income payment levels, (5) administrative functions and tasks, (6) referral/placement methods, (7) services, (8) provider training, (9) regulation, (10) legislation, and (11) assessment of barriers to entry of providers and clients.
DESIGN:	All 118 state-administered domiciliary care programs in United States were surveyed.
CONTENT:	See Purpose.
YEARS OF DATA COLLECTION:	1979-80 (one-time)
PUBLICATIONS:	Summary and Report of the National Survey of State-administered Domiciliary Care Programs in the Fifty States and the District of Columbia. Report to the Administration on Aging, prepared under DHHS/AoA Grant # 90-A-1659, by Kenneth J. Reichstein and Linda Bergofsky, Horizon House Institute, under subcontract from Hebrew Rehabilitation Center for the Aged, Boston, December 1980. State Regulations Governing Domiciliary Care Facilities for Adults and the Relationship Between Standards to Program Characteristics, Reichstein and Bergofsky, December 1980.
AVAILABILITY OF UNPUBLISHED DATA:	For information about availability of data tapes, contact Claire Gutkin.
CONTACT:	Claire Gutkin Hebrew Rehabilitation Center for the Aged (617) 325-8000

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Nationwide Study of Domiciliary Care: National Survey of Domiciliary Care**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x		Marriage
		Divorce
		HOUSING
x		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
x		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
x		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
x		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **Nationwide Study of Domiciliary Care: National Survey of Domiciliary Care**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Universe	Nonresponse Rate
Total	118 programs	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State program		
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **State Long-Term Care Ombudsman Report**

Project Director:
Director, Division of Operations and Financial Analysis
Office of State and Tribal Programs
Administration on Aging
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

PURPOSE: To comply with Section 307 (a)(12)(C) of the Older Americans Act, which requires state agencies on aging to collect and analyze data on complaints and conditions in long-term care facilities and report findings to the commissioner on aging. Also to obtain data on the development of state ombudsman programs.

DESIGN: Data on complaints and conditions in long-term care facilities are compiled by the state ombudsman office and are based on reports submitted to the state by local or regional substate ombudsman programs. Substate programs collect their data from staff and volunteers based in long-term care facilities or from ombudsman staff who respond to complaints made to the ombudsman office. Program information is compiled by the state ombudsman, based on staffing and funding levels reported by local programs.

CONTENT:

(1) Statistics on individual complaints, including number of complainants and complaints for the year, percentage investigated or referred by ombudsman, percentage verified, percentage resolved, percentage against particular types of facilities or other entities, sample of types of complaints.

(2) Description of one of more major long-term care issues identified by the ombudsman program and how the program has addressed the issue.

(3) Program information, including listing of state and all local programs, funding level and source of funding for all programs listed, type of agency or organization that operates the program, number of full-time and part-time professional staff and volunteers serving the program.

YEARS OF DATA COLLECTION: States have submitted reports annually since FY 1981. National summary reports were prepared for FY 1981 and FY 1982. Current reporting requirement has been approved by the Office of Management and Budget through FY 1986. The requirement is likely to be retained in the Older Americans Act for the indefinite future.

SPONSOR:	Administration on Aging (AoA), Department of Health and Human Services (DHHS)
TITLE:	**State Long-Term Care Ombudsman Report**
PUBLICATIONS:	National Summary of State Ombudsman Reports for U.S. FY 1981, Administration on Aging, October 1982. National Summary of State Ombudsman Reports for U.S. FY 1982--(AoA IM 84-11) Administration on Aging, December 1983.
AVAILABILITY OF UNPUBLISHED DATA:	Unpublished data available for United States FY 1983. State reports for United States FY 1983 and 1984 are available, but information has been compiled only partially for 1983 and not yet for 1984.
CONTACT:	Director, Division of Operations and Financial Analysis, AoA (202) 245-0727

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: State Long-Term Care Ombudsman Report

TYPES OF DATA COLLECTED

Data File
Public-Use Tape

DEMOGRAPHIC DATA
Educational level
Race
Ethnicity
Sex
Marital status
Migration or mobility

VITAL STATISTICS
Natality
Mortality
Marriage
Divorce

HOUSING
Type of dwelling
No. of persons in household
Relationship of persons in household

INCOME AND WEALTH
Labor force participation
Total income
Sources of income
Net assets

SOCIAL SERVICES

HEALTH RESOURCES
General hospitals
Private psychiatric hospitals
Public mental health hospitals
Nursing homes
Other institutional resources
Community-based resources
Health professions
Other professional resources

HEALTH EXPENSES
Costs of care
Out-of-pocket costs
Medicare
Medicaid
State expenditures
Private insurance

Data File
Public-Use Tape

NOT APPLICABLE

HEALTH
Acute and chronic conditions
Disability days
Chronic limitations:
  of activity
  of mobility
Impairments
Usual activity status

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
Cognitive impairment scale
Behavior problems
Depression
Alcohol use
Drug abuse

CHANGES IN HEALTH STATUS
Morbidity
Functional limitations
Self-perceived health

FUNCTIONAL LEVELS
Social interaction
Activities of daily living
Instrumental activities of daily living

HEALTH CARE UTILIZATION
General hospital services
Nursing home services
Home health care
Rehabilitation
Mental health hospitalization
Mental health outpatient services
Alcohol and drug abuse centers
Physician services/visits
Dental services/visits
Prescription drugs
Other

OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: State Long-Term Care Ombudsman Report

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State/Nat'l Summary for FY 81 and 82		State/Nat'l Summary for FY 81 and 82
Smallest unit	Local/Regional		Local/Regional
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR:	American Hospital Association
TITLE:	**Annual Survey of Hospitals**
	Project Director: Peter Kralovec, Director Hospital Data Center American Hospital Association 840 North Lake Drive Chicago, IL 60611
PURPOSE:	The continuation of a basic census-type survey of all U.S. hospitals.
DESIGN:	Full universe survey of all U.S. hospitals.
CONTENT:	Information collected includes hospital classification, services and facilities, beds and utilization by inpatient services, total facility beds and utilization, financial data, personnel on payroll, and medical staff organization.
YEARS OF DATA COLLECTION:	Annually since 1943.
PUBLICATIONS:	American Hospital Association Guide to the Health Care Field and Hospital Statistics.
AVAILABILITY OF UNPUBLISHED DATA:	Data can be purchased from the American Hospital Association.
CONTACT:	Ollie Williams Department of Data Services American Hospital Association (312) 280-6531

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SPONSOR: American Hospital Association

TITLE: **Annual Survey of Hospitals**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x	x	General hospitals
x	x	Private psychiatric hospitals
x	x	Public mental health hospitals
x	x	Nursing homes
x	x	Other institutional resources
x	x	Community-based resources
x	x	Health professions
x	x	Other professional resources
		HEALTH EXPENSES BY INSTITUTION
x	x	Costs of care
		Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION IN INSTITUTION
x	x	General hospital services
		Nursing home services
		Home health care
x	x	Rehabilitation
x	x	Mental health hospitalization
x	x	Mental health outpatient services
x	x	Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
x	x	Prescription drugs
x	x	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: American Hospital Association

TITLE: **Annual Survey of Hospitals**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Universe	Under 10%
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	National	National	National
Smallest unit	City	City	City
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR:	American Hospital Association
TITLE:	**National Hospital Panel Survey** Project Director: Peter Kralovec, Director Hospital Data Center American Hospital Association 840 North Lake Shore Drive Chicago, IL 60611
PURPOSE:	To collect data that are used in the longitudinal analyses and monitoring of seasonal variations of all community hospitals throughout the country.
DESIGN:	The sample size is approximately 34% of the universe of community hospitals registered by the American Hospital Association. This represents about 2,000 community hospitals; 70% response.
CONTENT:	Information collected involves beds and bassinets, utilization, finances, personnel, and utilization at ages 65 and over.
YEARS OF DATA COLLECTION:	Monthly since 1963.
PUBLICATIONS:	The National Hospital Panel Survey Report.
AVAILABILITY OF UNPUBLISHED DATA:	Data can be purchased from the American Hospital Association.
CONTACT:	Ollie Williams Department of Data Services American Hospital Association (312) 280-6531

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SPONSOR: American Hospital Association

TITLE: **National Hospital Panel Survey**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x		Total income
x		Sources of income
x		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x	x	General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
x	x	Other institutional resources
x	x	Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION (BY INSTITUTION)
x	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: American Hospital Association

TITLE: **National Hospital Panel Survey**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Hospital Sample	Nonresponse Rate
Total	2,000	20% (approx.)
Under 65		
65+		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	National	National	National
Smallest unit	City	City	City
Age classes			
Single years			
60-64			
65+	x	x	x
65-74, 75-84, 85+			
Other			

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SPONSOR:	American Hospital Association
TITLE:	**Survey of Medical Rehabilitation Hospitals and Units, 1983**
	Project Director: Peter Kralovec, Director Hospital Data Center American Hospital Association 840 North Lake Shore Drive Chicago, IL 60611
PURPOSE:	To obtain information about the number of programs, types of services provided, patient referral sources, staffing patterns, and sources of payment for rehabilitation programs nationwide. To compare data with prior surveys to determine trends in numbers and size of programs and the extent of services offered.
DESIGN:	Rehabilitation hospitals, children's rehabilitation hospitals, rehabilitation units in general, and other speciality hospitals. The list of hospitals was compiled from the 1982 Annual Survey of Hospitals. Response rate was 64%.
CONTENT:	Classification of facility providing rehabilitation care, beds and utilization information for these facilities, census information, referral sources, service information, programs provided on an inpatient and outpatient basis, financial data, and staffing information.
YEARS OF DATA COLLECTION:	1983, 1981, 1979; principal items comparable in all three studies, but specific information differs.
PUBLICATIONS:	Inpatient Medical Rehabilitation: 1979 Survey of Hospitals and Units. Archives of Physical-Medical Rehabilitation, Vol. 61, August 1980. Inpatient Medical Rehabilitation: Results of the 1981 Survey of Hospitals and Units. Archives of Physical-Medical Rehabilitation, Vol. 64, No. 8, August 1983.
AVAILABILITY OF UNPUBLISHED DATA:	Data can be purchased from the American Hospital Association.
CONTACT:	Ollie Williams Department of Data Services American Hospital Association (312) 280-6531

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SPONSOR: American Hospital Association

TITLE: **Survey of Medical Rehabilitation Hospitals and Units, 1983**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x	x	General hospitals
x	x	Private psychiatric hospitals
x	x	Public mental health hospitals
x	x	Nursing homes
x	x	Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
		Nursing home services
x	x	Home health care
x	x	Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: American Hospital Association

TITLE: Survey of Medical Rehabilitation Hospitals and Units, 1983

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of Institutions in Sample	Nonresponse Rate
Total	2,269	36%
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	National	National	National
Smallest unit	City	City	City
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR:	American Hospital Association
TITLE:	**Survey of Medical Staff Organization, 1982**
	Project Director: Peter Kralovec, Director Hospital Data Center American Hospital Association 840 North Lake Shore Drive Chicago, IL 60611
PURPOSE:	To obtain information on privileges, administrative functions, specialty composition, and concentration of hospital use by its medical staff.
DESIGN:	A national representative sample of 3,142 community hospitals. Response rate to study was 67.1%.
CONTENT:	Information collected involves physician hospital privileges, composition and role of medical staff committees, and physician participation in hospital governance and organization.
YEARS OF DATA COLLECTION:	1982
PUBLICATIONS:	Contact A. Morrisey, Hospital Research Center, American Hospital Association. Telephone: (312) 280-6675.
AVAILABILITY OF UNPUBLISHED DATA:	Data tapes can be purchased from the American Hospital Association.
CONTACT:	Ollie Williams Department of Data Services American Hospital Association (312) 280-6531

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SPONSOR: American Hospital Association

TITLE: **Survey of Medical Staff Organization, 1982**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x	x	General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
x	x	Community-based resources
x	x	Health professions
x	x	Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: American Hospital Association

TITLE: Survey of Medical Staff Organization, 1982

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	National	National	National
Smallest unit	City	City	City
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSORS:	Assistant Secretary for Planning and Evaluation (ASPE), Health Care Financing Administration (HCFA), and Administration on Aging (AoA), Department of Health and Human Services (DHHS)
TITLE:	**National Long-Term Care Channeling Demonstration Program (NLTCDP)**
CONTRACTOR:	Mathematica Policy Research, Inc. P.O. Box 2393 Princeton, NJ 08540
	Project Director: George J. Carcagno Mathematica Policy Research, Inc. (609) 799-2600
	Program Manager: Mary Harahan, Director Division of Disability, Aging, and Long-Term Care Policy Assistant Secretary for Planning and Evaluation Hubert H. Humphrey Building, Room 410-G 200 Independence Avenue, SW Washington, DC 20201
PURPOSE:	A demonstration program designed to explore systematically a community-based approach to long-term care for elderly and impaired persons 65 and over who were at risk of nursing home placement. Two basic models are being tested: a basic case management model and a financial control model. A total of ten community projects in 10 different states implemented the program. Participating states were: Florida, Kentucky, Maine, Maryland, Massachusetts, New Jersey, New York, Ohio, Pennsylvania, and Texas.
DESIGN:	Randomized experimental design. At each of the 10 project sites, eligible subjects were randomly assigned to treatment or control group status. Total research sample was 6,326 persons (3,702 treatment and 2,624 controls). Sample was followed at 6 months, 12 months, and (for half the sample) 18 months.
CONTENT:	Applicants were screened to determine eligibility. Interviews for eligible sample members focused on socioeconomic status, health status, functional limitations, informal supports, and use of formal services.
YEARS OF DATA COLLECTION:	1982-85.

SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE), Health Care Financing Administration (HCFA), and Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **National Long-Term Care Channeling Demonstration Program (NLTCDP)**

PUBLICATIONS: Series of 20 technical reports, including a final summary report due March 1986, which will be available through the Assistant Secretary for Planning and Evaluation or Mathematica Policy Research, Inc.

AVAILABILITY OF UNPUBLISHED DATA: Public use tape expected by spring 1986 will be available through the National Technical Information Service or the Inter-university Consortium for Political and Social Research.

CONTACT: Robert F. Clark
ASPE
(202) 245-6172

SPONSOR: Assistant Secretary for Planning and Evaluation (ASPE), Health Care Financing Administration (HCFA), and Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **National Long-Term Care Channeling Demonstration Program (NLTCDP)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
x	x	Natality
x	x	Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
x	x	SOCIAL SERVICES
		HEALTH RESOURCES
x	x	General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
x	x	Nursing homes
x	x	Other institutional resources
x	x	Community-based resources
x	x	Health professions
x	x	Other professional resources
		HEALTH EXPENSES
x	x	Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x	x	Cognitive impairment scale
x	x	Behavior problems
x	x	Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x	x	Morbidity
x	x	Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
x	x	Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
x	x	Prescription drugs
x	x	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Assistant Secretary for Planning and Evaluation (ASPE), Health Care Financing Administration (HCFA), and Administration on Aging (AoA), Department of Health and Human Services (DHHS)

TITLE: **National Long-Term Care Channeling Demonstration Program (NLTCDP)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	6,326	*
Under 65		
65-74	1,771	*
75-84	2,784	*
85+	1,771	*

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* Nonresponse rate varies according to particular analysis sample (e.g., 6 month follow-up, 12 month follow-up) used.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x	x	
Geographic data			
Largest unit	Aggregate of 10 sites		
Smallest unit	Aggregate of 10 sites		
Age classes			
Single years	x		
60-64			
65+	x	x	x
65-74, 75-84, 85+	x	x	x
Other			

SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE) and Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **National Survey of Long-Term Care/National Survey of Caregivers, 1982**

Project Directors:
Paul D. Gayer, Economist
Division of Long-Term Care Policy
Office of Social Services Policy
ASPE/SSP
U.S. Department of Health and Human Services
Washington, DC 20201

Candace Macken, Statistician
Office of Research
Office of Research and Demonstrations
Health Care Financing Administration
6340 Security Boulevard
Baltimore, MD 21207

PURPOSE: To provide information on the noninstitutionalized population over 65 needing assistance with daily living and on their caregivers.

DESIGN: National sample of the population over 65, screened for long-term dependency: 34,000 cases screened, 6,400 dependent found. Nonresponse was 4.7%. Linked to Caregivers Survey. Interviews with about 2,000 unpaid informal caregivers who provide assistance to the dependent elderly who were interviewed.

CONTENT: Demographics, functioning, dependence, impairment, disease, medical services, informal care, income, assets, veterans status, cognitive functioning, social interaction, housing, and household relationships for sample of dependent individuals over 65.

YEARS OF DATA COLLECTION: 1982.

PUBLICATIONS: Profile of Functionally Impaired Persons Living in the Community, 1982 by Candace Macken, Health Care Financing Review, Winter 1986.

AVAILABILITY OF UNPUBLISHED DATA: Expected to be available by early 1986.

CONTACT:
Paul D. Gayer
(202) 245-6613

Candace Macken
(301) 597-1435

SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE) and Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **National Survey of Long-Term Care/National Survey of Caregivers, 1982**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
x	x	Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x	x	Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x	x	Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
		Rehabilitation
x	x	Mental health hospitalization
x	x	Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
x	x	Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE) and Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **National Survey of Long-Term Care/National Survey of Caregivers, 1982**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	6,400	4.7%
Under 65		
65-74		
75-84		
85+		

Caregivers, total 2,000

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	Nation	Nation	
Smallest unit	Zip code	Census region	
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), and National Science Foundation (NSF)

AGENCY: Survey Research Center, University of Michigan

TITLE: **Panel Study of Income Dynamics (PSID)**

Project Directors:
James Morgan and Greg Duncan
Economic Behavior Program
Survey Research Center (SRC)
University of Michigan
Box 1248
Ann Arbor, MI 48106

PURPOSE: To study dynamics of family economic status for a nationally representative sample of the U.S. population.

DESIGN: Probability sample of about 3,000 dwellings in 1968 drawn from SRC sampling frame, combined with about 2,000 low-income respondents from the Survey of Economic Opportunity. Response rate was 76% in 1968, 86% in 1969, and 97-98% each year from 1970-1985. This is a longitudinal survey, conducting interviews annually with heads of original 1968 families and heads of all newly formed families. Local labor market information from state unemployment offices is linked to the data.

CONTENT: Main topics include family composition; housing, food and utility expenditures; employment history of head and wife; sources of family income and amounts. Selected special topics are often included and have focused on: health status; marriage and fertility history; education history; savings, wealth, and assets; fringe benefits and retirement pensions and plans.

YEARS OF DATA COLLECTION: The sample has been interviewed annually since 1968 and is funded to continue through 1986. Funding has been requested for 1987-91. Data for a given interview year is released approximately 2 years after the interview.

PUBLICATIONS: A complete bibliography is available from the project directors. Morgan, James N., et al; editors: *Five Thousand American Families: Patterns of Economic Progress*. Vol. I-IX. Ann Arbor: University of Michigan Institute for Social Research.

Duncan, Greg J., et al; 1983. *Years of Poverty, Years of Plenty*. Ann Arbor: University of Michigan Institute for Social Research.

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SPONSORS: **Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), and National Science Foundation (NSF)**

TITLE: **Panel Study of Income Dynamics (PSID)**

AVAILABILITY OF UNPUBLISHED DATA: Data are available on tapes (ICPSR 7439) from the Inter-university Consortium on Political and Social Research, University of Michigan. Also available are documentation volumes and a user guide to the data. Inter-university Consortium on Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

CONTACT:
Janet Vavra
Inter-university Consortium on Political and Social Research
(313) 764-2570

SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), and National Science Foundation (NSF)

TITLE: **Panel Study of Income Dynamics (PSID)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
	x	Migration or mobility
		VITAL STATISTICS
	x	Natality
	x	Mortality
	x	Marriage
	x	Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
	x	Sources of income
	x(1984)	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
	x	Disability days
		Chronic limitations:
	x(1986)	of activity
	x(1986)	of mobility
		Impairments
	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
	x	Morbidity
	x	Functional limitations
	x	Self-perceived health
		FUNCTIONAL LEVELS
	x	Social interaction
	x(1986)	Activities of daily living
	x(1986)	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), and National Science Foundation (NSF)

TITLE: **Panel Study of Income Dynamics (PSID)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	7,030 in 1985	3% annually
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth		x	
Social Security no.			
Veteran status		x	
Geographic data			
Largest unit		Census region	
Smallest unit		State and county	
Age classes			
Single years		x	
60-64		x	
65+		x	
65-74, 75-84, 85+		x	
Other			

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SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), with Bureau of the Census

TITLE: **Survey of Institutionalized Persons, 1976**

Project Director:
Evan Davey
Assistant Division Chief
for Special Surveys
Demographic Surveys Division
Bureau of Census
U.S. Department of Commerce
Washington, DC 20233

PURPOSE: To obtain information about the services and resources of long-term care facilities providing care for persons with chronic conditions, diseases and/or handicaps; institutions for the mentally ill and mentally retarded; nursing homes and homes for the aged; and residential schools and treatment centers.

DESIGN: Universe--long-term care portion of the 1973 Master Facility Inventory: 928 of 26,003 institutions were selected--98.5% of the eligible participated.

9,337 residents were selected for inclusion.
Of these:

- 96.9% had administrative records data transcribed;
- 96.8% completed a staff interview about resident activities;
- 60.6% of the residents completed interviews--32.2% were not contacted by institution request;
- 4,177 families were selected for interview (next of kin to sample person); of these, 79.7% were located and interviewed.

CONTENT:

(1) Facility; ownership; type of care provided; size; staff composition.

(2) Administrative records of sample person; reason for admission, type of care; source of payment.

(3) Staff interview; general mobility; personal care needed; aids used; activities socially.

(4) Resident interview; preinstitutional employment; living arrangements prior to entry; visitors; opinion of quality of life in institution.

(5) Family interview; resident's demographic background; decision to institutionalize and alternatives considered; potential for discharge; family's satisfaction with institution; family's financial responsibilities.

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SPONSORS:	Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), with Bureau of the Census
TITLE:	**Survey of Institutionalized Persons, 1976**
YEARS OF DATA COLLECTION:	1976 (one time) Report issued 1978
PUBLICATIONS:	Census Publication P-23, No. 69. 1976 Survey of Institutionalized Persons: A Study of Persons Receiving Long-Term Care. Technical Paper 42. 1976 Survey of Institutionalized Persons: Methods and Procedures.
AVAILABILITY OF UNPUBLISHED DATA:	Public use data tapes available for sale from the Bureau of the Census. Data tapes are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106. (ICPSR 7866)
CONTACT:	Evan Davey (301) 763-2778

SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), with Bureau of the Census

TITLE: **Survey of Institutionalized Persons, 1976**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
X	X	Educational level
X	X	Race
		Ethnicity
X	X	Sex
X	X	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
X	X	Labor force participation
X	X	Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
X	X	Costs of care
X	X	Out-of-pocket costs
X	X	Medicare
X	X	Medicaid
X	X	State expenditures
X	X	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
X	X	of activity
X	X	of mobility
X	X	Impairments
X	X	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
X	X	Social interaction
X	X	Activities of daily living
X	X	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
X	X	Nursing home services
		Home health care
X	X	Rehabilitation
X	X	Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
X	X	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSORS: Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services (DHHS), with Bureau of the Census

TITLE: Survey of Institutionalized Persons, 1976

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	9,036 (100%)	3.2%
Under 65	Approx. 31.3% (2,831)	
65-79	Approx. 25.2% (2,278)	
80+	Approx. 41.1% (3,714)	
Not reported	Approx. 2.4% (214)	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status	*		
Geographic data			
Largest unit	U.S.		
Smallest unit	U.S.		
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			50-64, 65-79, 80+

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* Receipt of veterans' benefits is identified

SPONSOR: Bureau of Census

TITLE: **County and City Data Book (CCDB)**

Project Director:
Glenn W. King
Chief, Statistical Compendia Staff
Data User Services Division
Bureau of the Census
U.S. Department of Commerce
Washington, DC 20233

PURPOSE: To provide statistical information for states, counties, and cities on subjects such as population, vital statistics, housing, and income.

DESIGN: Data are for geographic units in the United States, compiled from a number of sources.

CONTENT: Continuous collection of county- and city-level data. Information is processed as various data series are produced. Therefore some data are annual, some periodic, and some once in a decade.

YEARS OF DATA COLLECTION: Publication produced roughly every 5 years, though data are collected and processed continuously. CCDB 1983 is the most current edition; next edition is projected for 1987.

PUBLICATIONS: County and City Data Book 1983. Previous editions: 1944, 1949, 1952, 1956, 1962, 1967, 1972, 1977.

AVAILABILITY OF UNPUBLISHED DATA:
Public use files:
County and City Data Book 1983 (most recent)
CO-STAT 1 (County Statistics 1)
County and City Data Book floppy disks

CONTACT:
David Shaw
Customer Services
Data User Services Division
Bureau of the Census
(301) 763-1034

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SPONSOR: Bureau of the Census

TITLE: **County and City Data Book (CCDB)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	Aggregate Data
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
	x	Migration or mobility
		VITAL STATISTICS
	x	Natality
	x	Mortality
	x	Marriage
	x	Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
	x	General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
	x	Nursing homes
		Other institutional resources
		Community-based resources
	x	Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
	x	Medicare
	x	Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	Aggregate Data
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Bureau of the Census

TITLE: **County and City Data Book (CCDB)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit		U.S.	U.S.
Smallest unit		County, city	County, city
Age classes			
Single years			
60-64		Co-Stat 1	Co-Stat 1
65+		x	x
65-74, 75-84, 85+			
Other			

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SPONSORS: Bureau of the Census and Bureau of Labor Statistics (BLS)

TITLE: **Current Population Survey (CPS)**

Project Director:
Kenneth Riccini
Chief, CPS Branch
Demographic Surveys Division
Bureau of the Census
U.S. Department of Commerce
Washington, DC 20233

PURPOSE: To provide current data on employment and unemployment; supplements added later since this was much cheaper and faster than designing separate surveys for each topic.

DESIGN: Universe is the civilian noninstitutional population; sample is a multistage clustered sample comprising about 730 primary sampling units (PSUs) encompassing roughly 1,900 geographic areas. Sample consists of about 72,000 addresses a month, of which about 59,000 are interviewed. Nonresponse rate for eligible households is about 4.5 %. Sample is rotated so that 75% of the addresses are common in consecutive months and 50% are the same in any 2 months 1 year apart.

CONTENT: Monthly data on demographic characteristics and labor force status (hours worked, occupation and industry, whether looked for work, duration of unemployment, whether on layoff, etc.). Supplemental data collected at varying intervals on topics such as annual income, work experience, migration, fertility, immunization status, school enrollment, alimony and child support, pension plans, etc.

YEARS OF DATA COLLECTION: Monthly since 1942; labor force data released by the Bureau of Labor Statistics the first Friday of the following month. Supplement data generally released in reports and public use microdata file from 6-9 months after collection.

PUBLICATIONS: Labor Force Data: Employment and Earnings, Monthly Labor Review, Bureau of Labor Statistics.
Supplement Data: by sponsors; income data in Census Bureau's P-60 series, other census data in P-20 reports.

AVAILABILITY OF UNPUBLISHED DATA: Public use microdata tapes available beginning 1968. Special tabulations can be generated at cost given availability of staff.

Data tapes are also in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

CONTACT:
Kenneth Riccini
(301) 763-2773

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SPONSOR: Bureau of the Census and Bureau of Labor Statistics (BLS)

TITLE: **Current Population Survey (CPS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
*	*	Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
*	*	Marriage
*	*	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
*	*	Total income
*	*	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
*	*	Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
*	*	Smoking

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* Available as supplemental data only for certain months.

SPONSOR: Bureau of the Census and Bureau of Labor Statistics (BLS)

TITLE: **Current Population Survey (CPS)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	120,000	
Under 60	95,100	
60-69	13,000	
70-79	8,500	
80-89	3,000	
90+	400	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.	x		
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	Enumeration district	Pop. = 250K	Large SMSAs
Age classes			
Single years	x	x	
60-64			Some
65+			Some
65-74, 75-84, 85+			
Other			

SPONSOR: Bureau of the Census

TITLE: **Decennial Census of Population and Housing**

Project Director:
John G. Keane, Director
Bureau of the Census
U.S. Department of Commerce
Washington, DC 20233

PURPOSE: The Constitution mandates that a census be taken every 10 years to provide a basis for reapportioning seats in the House of Representatives.

DESIGN: In the 1980 census, each household in the country received one of two versions of the census questionnaire: a short form containing a limited number of basic population and housing questions or a long form containing these questions as well as a number of additional questions. Two sampling rates were used for the long form. For most of the country, one in every six households (about 17 percent) received the long form or sample questionnaire; in counties, incorporated places and functioning minor civil divisions estimated to have fewer than 2,500 inhabitants, every other household (50 percent) received the sample questionnaire to enhance the reliability of sample data in small areas.

CONTENT: The information collected describes the basic demographic and housing characteristics of the population. There are some comparability problems between censuses because of changes in definitions and procedures. A section on comparability is included in most reports.

YEARS OF DATA COLLECTION: Every 10 years since 1790; the twentieth census was conducted as of April 1, 1980.

PUBLICATIONS: The *Bureau of the Census Catalog*, 1985, provides a listing of all 1980 census products available through early 1985. Listings of subsequent releases can be found in the *Monthly Product Announcement*. Products from earlier censuses can be found in *Bureau of the Census Catalog of Publications: 1790-1972*. Information published between 1972 and 1979 can be found in the individual annual catalogs.

AVAILABILITY OF UNPUBLISHED DATA: Data are available from summary tape files and microfiche. Other special files include public-use microdata samples. Information is available on tape primarily from the 1980 and 1970 censuses. Public use sample tapes are available for 1940, 1950, and 1960. The Census Bureau will produce

SPONSOR: Bureau of the Census

TITLE: **Decennial Census of Population and Housing**

special tabulations primarily of 1980 and 1970 data from basic record tapes on a reimbursable basis. Requests for special tabulations of population items should be sent to Paula Schneider, Program Director, Population Division, Bureau of the Census, Washington, DC 20233. Housing requests should be sent to Arthur F. Young, Chief, Housing Division.

Data tapes are also in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, Box 1248, Ann Arbor, MI 48106.

CONTACT:
Customer Services
Data User Services Division
Bureau of the Census
(301) 763-4100

SPONSOR: Bureau of the Census

TITLE: **Decennial Census of Population and Housing**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
x	x	Private psychiatric hospitals
x	x	Public mental health hospitals
x	x	Nursing homes
x	x	Other institutional resources
		Community-based resources
x	x	Health professions
x	x	Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Bureau of the Census

TITLE: **Decennial Census of Population and Housing**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	100% item	2.9% (allocated)
Under 65	100% item	
65-74	100% item	
75-84	100% item	
85+	100% item	
65+	100% item	4.0% (allocated)

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	Blocks	Blocks	Census tracts
Age classes			
Single years	x	x	x
60-64	x	x	x
65+	x	x	x
65-74, 75-84, 85+	x	x	x
Other			

Counts are available for the age classes given; however, not all characteristics are cross-tabulated by these age classes.

SPONSOR: Bureau of the Census

TITLE: **State and Metropolitan Area Data Book**

Project Director:
Glenn W. King
Chief, Statistical Compendia Staff
Data User Services Division
Bureau of the Census
U.S. Department of Commerce
Washington, DC 20233

PURPOSE: To provide statistical information for states, SMSAs, central cities, and metropolitan counties on births, deaths, health care workers, hospitals, etc.

DESIGN: Data are for geographic units in the United States, compiled from a number of sources.

CONTENT: Annual collection of county- and city-level data. Periodic collection of state-level data. Data vary between annual and decennial.

YEARS OF DATA COLLECTION: Roughly every 3 years; next edition projected for early 1986.

PUBLICATIONS: State and Metropolitan Area Data Book, 1979 and 1982 editions; 1985 edition forthcoming.

AVAILABILITY OF UNPUBLISHED DATA: Tape files are available for 1979, 1982. A file called CO-STAT 1 is also available for 1983. It contains county data from the State and Metropolitan Area Data Book and the County and City Data Book. CO-STAT 2 with updated data series will be available in early 1986.

CONTACT:
David Shaw
Customer Services
Data User Services Division
Bureau of the Census
(301) 763-1034

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SPONSOR: Bureau of the Census

TITLE: **State and Metropolitan Area Data Book**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	Aggregate data
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
	x	Migration or mobility
		VITAL STATISTICS
	x	Natality
	x	Mortality
	x	Marriage
	x	Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
	x	General hospitals
	x	Private psychiatric hospitals
	x	Public mental health hospitals
	x	Nursing homes
	x	Other institutional resources
		Community-based resources
	x	Health professions
		Other professional resources
		HEALTH EXPENSES
	x	Costs of care
	x	Out-of-pocket costs
	x	Medicare
	x	Medicaid
	x	State expenditures
	x	Private insurance

Data File	Public-Use Tape	Aggregate Data
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
	x	General hospital services
	x	Nursing home services
		Home health care
		Rehabilitation
	x	Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Bureau of the Census

TITLE: State and Metropolitan Area Data Book

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit		U.S.	U.S.
Smallest unit		County, city	County, city
Age classes			
Single years			
60-64			
85+		x	x
65-74, 75-84, 85+			
Other			

SPONSOR: Bureau of the Census

TITLE: **Survey of Income and Program Participation (SIPP)**

Project Director: Roger A. Herriot
Chief, Population Division
Bureau of the Census
U.S. Department of Commerce
Washington, DC 20233

PURPOSE: The objectives of SIPP include the collection of data on cash and noncash income for the purpose of studying the efficiency of transfer and service programs, the estimation of future program costs and coverage, and the assessment of the effects of proposed policy changes. SIPP will also satisfy the need for improved data on the economic situation of persons and families in the United States to produce improved estimates of the distribution of income, poverty, and wealth.

DESIGN: SIPP started in October 1983 as an ongoing nationally representative survey of the Bureau of the Census with one sample panel of approximately 21,000 households in 174 primary sample units selected to represent the noninstitutional population of the United States. The sample design is self-weighting.

Each household is interviewed once every 4 months for 2 2/3 years to produce sufficient data for longitudinal analyses while providing a relatively short recall period for reporting monthly income and labor force activity. The reference period for the principal survey items is the four months preceding the interview.

Each February a new panel goes into the field with a sample size of about 15,000 households. Members of each panel go through eight interviews or waves. In order to spread the workload for the field staff, members of each panel are divided into four groups of equal size called rotation groups. Each month in turn one rotation group receives its interview. Thus the four month relevance period is different for each rotation group.

At this time, cross-sectional unit noninterview rates are available for the first two waves of SIPP. Unit noninterview rates provide a measure of the success/failure of the SIPP field work. While refusals are the largest part of the type A rate, it also includes "no one home" and "temporarily absent" households. In Wave 1 (all rotation groups), the mean type A rate was 4.8%; in Wave 2, 3.7%, in Wave 3, 5.6%. The cumulative Type A rate after 3 interviews is approximately 12%.

SPONSOR: Bureau of the Census

TITLE: **Survey of Income and Program Participation (SIPP)**

A study has been implemented to validate electronically reported social security numbers (SSN), to manually search for SSNs not reported correctly, and to use the panel aspect of the SIPP to correct and verify a respondent's SSN. Having established the link for matching activities, work is now proceeding on identifying content and availability of administrative record systems for use in:
(a) data augmentation for research and estimates and (b) survey data evaluation.

Another aspect of this work is the development of a demonstration and feasibility study to evaluate SIPP data from Waves 1 and 2 using several federal administrative record systems such as the Master Beneficiary Record (SSA), and the Supplemental Security Record (SSA).

CONTENT: The content of SIPP was developed around a "core" of labor force and income questions designed to measure the economic situation of persons ages 15 and over in the United States. These questions expand the data currently available on the distribution of cash and noncash income and are repeated at each interviewing wave.

Specific questions are asked about the types of income received, including transfer payments and noncash benefits from various programs, disability, assets and liabilities, pension coverage, taxes, and many other items, for each month of the reference period, as well as labor force status, which is collected on a weekly basis. A few questions on private health insurance coverage are also included in the core.

The SIPP has been designed to provide a broader context for analysis by adding questions on a variety of topics not covered in the core section. These questions are labeled "fixed topical modules" and are assigned to particular interviewing waves of the survey. For example, questions are asked about health and disability in the third interview of the 1984 panel, and questions are asked about the value of assets and liabilities in the fourth interview of the 1984 panel. If more than one observation is needed, questions on one wave may be repeated on a later wave.

In response to program planning and policy analysis data requirements, the final component of the SIPP content consists of modules of questions designed in consultation with other federal agencies. These variable topical modules are designed to be flexible and to meet immediate policy analysis needs. For example, Wave 4 includes data on pension plan coverage and retirement plans and expectations.

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SPONSOR: Bureau of the Census

TITLE: **Survey of Income and Program Participation (SIPP)**

YEARS OF DATA COLLECTION: The initial interviews for the 1984 panel began in October 1983. Seven of nine proposed waves of the 1984 panel have been completed. In February 1985 a new panel began and three waves of interviewing have been completed. A new panel will be implemented each February. The first five quarterly reports--third quarter 1983, fourth quarter 1983, first quarter 1984, second quarter 1984, and third quarter 1985--have been released.

PUBLICATIONS: SIPP Working Paper Series, Nos. 8401-8407 and 8501-8505, Bureau of the Census.

Survey of Income and Program Participation and Related Longitudinal Surveys: 1984 (selected papers given at the 1984 annual meeting of the American Statistical Association in Philadelphia, August 13-16, 1984), Bureau of the Census, Washington, DC, 1984.

Survey of Income and Program Participation: 1985 (selected papers given at the 1985 annual meeting of the American Statistical Association in Las Vegas, Nevada, August 5-8, 1985) Bureau of the Census, Washington, DC, 1985.

"Economic Characteristics of Households in the United States," Current Population Reports, Series P-70. Bureau of the Census, U.S. Department of Commerce (quarterly reports, five of which have been released).

AVAILABILITY OF UNPUBLISHED DATA: The SIPP file is a questionnaire image file. Both the internal file and the public-use data tape mirror each other except for some geographic and income recodes. The files are available in two formats: one that contains nested record types for households, persons, labor force activity, and asset income, which may be linked together, and one that contains all the information collected directly linked to each person record.

Survey of Income and Program Participation (SIPP) micro data files for Waves 1-4 of the 1984 panel have been released.

Data tapes are part of the collection of the Inter-university Consortium for Political and Social Research, Box 1248, Ann Arbor, MI 48106. They are also in the collection at the Survey Data Center (funded by the National Science Foundation) at the University of Wisconsin.

CONTACT:
Customer Services
Data User Services Division
Bureau of the Census
(301) 763-4100

SPONSOR: Bureau of the Census

TITLE: **Survey of Income and Program Participation (SIPP)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
x	x	Natality
x	x	Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x	x	Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
*	*	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services (some)
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	Health Care in home by nonprofit organization

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* 1984 Topical Module

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SPONSOR: Bureau of the Census

TITLE: **Survey of Income and Program Participation (SIPP)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample
(For first panel)	
Total	53,721
Under 65	47,539
65-74	3,880
75-84	1,856
85+	446

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.	x		
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	County	250,000+	Region
Age classes			
Single years	x	x to 85+	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR:	Bureau of Labor Statistics (BLS)
TITLE:	**Consumer Expenditure Survey**
	Project Director: Eva E. Jacobs Chief, Division of Consumer Expenditure Surveys Bureau of Labor Statistics U.S. Department of Labor 600 E Street, NW Washington, DC 20212
PURPOSE:	To provide a continuous flow of data on consumer expenditure and socioeconomic characteristics.
DESIGN:	The Consumer Expenditure Survey is a national probability sample of households designed to be representative of the population of the United States. Primary sampling units (PSUs) were selected that consisted of counties or parts of counties, groups of counties, or independent cities. The set of sample PSUs used for the survey is composed of 101 areas of which 85 are urban. Survey is in two parts. In the Diary Survey, 5,000 respondents per year keep a two-week diary. In the Interview Survey, 5,000 respondents are interviewed every three months 5 times. Sample is rotating. Response rates are about 85-90%.
CONTENT:	All expenditures and many characteristics are collected. Income and assets are collected in the second and fifth interviews.
YEARS OF DATA COLLECTION:	Ongoing since 1980. Expected release dates: 1984 - Surveys - March 1986 1985 - Surveys - March 1987
PUBLICATIONS:	BLS Bulletin 2173; 1980-1981 Diary Survey. BLS Bulletin 2225; 1980-1981 Interview Survey. BLS Bulletin 2246; 1982-1983 Interview Survey.
AVAILABILITY OF UNPUBLISHED DATA:	Public-use data tapes are available from the Bureau of Labor Statistics.
CONTACT:	Eva E. Jacobs (202) 272-5156

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Consumer Expenditure Survey**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Consumer Expenditure Survey**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age (Ref. Person)	1980 Number in Sample	
Total	4,740	Sample by age will change over time with demographic changes. Average total sample--approx. 5,000.
Under 65	3,739	
65-74	618	
75-84	319	
85+	65	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	Region	Region	Region
Smallest unit	PSU	SMSA size	Selected SMSAs
Age classes			
Single years	x	x	
60-64			
65+			x
65-74, 75-84, 85+			
Other: 65-74, 75+	x		x

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Consumer Price Index (CPI)**

Project Director: John F. Early
Assistant Commissioner for
Consumer Prices and Price Indexes
Bureau of Labor Statistics
U.S. Department of Labor
441 G Street, NW
Washington, DC 20212

PURPOSE: Provide basis for cost-of-living adjustments in wages during World War I.

DESIGN: Samples of areas, outlets, and items. Weighting pattern based on Survey of Consumer Expenditures (See BLS Handbook of Methods, Volume II, Bulletin 2134-2, April 1984).

CONTENT: Prices are collected for a sample of medical care commodities and services (and other household expenditures). Samples are updated periodically to reflect the changes in expenditure patterns and commodities and services consumed. The last major revision was 1978; the next is scheduled for 1987.

YEARS OF DATA COLLECTION: Monthly data for the U.S. city average since 1913. Monthly, bimonthly, or quarterly data for selected metropolitan areas since 1913. There are currently 5 monthly areas and 23 bimonthly areas.

PUBLICATIONS: Data: CPI News (press release), CPI Detailed Report.
Methodology: BLS Handbook of Methods, Vol. II, 1984.

AVAILABILITY OF UNPUBLISHED DATA: None. Basic data are collected under a pledge of confidentiality to the respondents. Only published data are available.

CONTACT: Patrick C. Jackman
Bureau of Labor Statistics
(202) 272-5160

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: Consumer Price Index (CPI)

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	Changes in charges or prices for selected medical care commodities and services

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SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Consumer Price Index (CPI)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S. city average		
Smallest unit	28 Selected local areas		
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Industry Wage Survey: Hospitals**

Project Director: Sandra King
Project Director, Industry Studies
Office of Wages and Industrial Relations
Bureau of Labor Statistics
U.S. Department of Labor
441 G Street, NW
Washington, DC 20212

PURPOSE: To gather and analyze data on the occupational wage structure of various manufacturing and nonmanufacturing industries.

DESIGN: Universe is the Bureau's file derived from state unemployment insurance reports. The survey is a probability sample of hospitals that employ 100 workers or more. Data collected from about 600 hospitals in 22 metropolitan areas; response rate is about 90%.

CONTENT: Earnings of individual hospital workers matched to detailed occupational descriptions; sex of workers; incidence of employee benefits (holidays, vacation, health and life insurance, retirement plans); and hospital practices (work schedule, shift).

YEARS OF DATA COLLECTION: Generally done every 3 years.
1985 data available in early 1986. Data have been collected for 1981, 1978, 1975, 1972, 1969, 1966, 1963, 1960, and 1957.

PUBLICATIONS: BLS Bulletins titled *Industry Wage Survey: Hospitals (date)*. Bulletin numbers are: 2204 (1981), 2069 (1978), 1949 (1975), 1829 (1972), 1688 (1969), 1553 (1966), 1409 (1963), 1294 (1960), 1210 (1957).

AVAILABILITY OF UNPUBLISHED DATA: Unpublished data can be made available on a fee (contract) basis.

CONTACT: Sandra King
(202) 523-1309

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Industry Wage Survey: Hospitals**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x	x	General hospitals
x	x	Private psychiatric hospitals
x	x	Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
x	x	Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Industry Wage Survey: Hospitals**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	Metropolitan area	Metropolitan area	Metropolitan area
Smallest unit	Metropolitan area	Metropolitan area	Metropolitan area
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR:	Bureau of Labor Statistics (BLS)
TITLE:	**Industry Wage Survey: Nursing Homes**
	Project Director: Sandra King Project Director, Industry Studies Office of Wages and Industrial Relations Bureau of Labor Statistics U.S. Department of Labor 441 G Street, NW Washington, DC 20212
PURPOSE:	To gather and analyze data on the occupational wage structure of various manufacturing and nonmanufacturing industries.
DESIGN:	Universe is Bureau's file from state unemployment insurance lists. The survey is a probability sample. Data are collected from about 1,100 nursing homes in 22 metropolitan areas; response rate is 90%.
CONTENT:	Earnings of individual workers matched to detailed occupational descriptions; sex of workers; incidence of fringe benefits; and nursing home practices (work schedule, shift).
YEARS OF DATA COLLECTION:	Generally done every 3 to 4 years. 1985 data available early in 1986; data have been collected for 1981, 1978, 1976, 1973, 1967-68.
PUBLICATIONS:	BLS Bulletins titled Industry Wage Survey: Nursing Homes (date). BLS Bulletin numbers are: 2142 (1981), 2069 (1978), 1974 (1976), 1855 (1973), 1638 (1967-68).
AVAILABILITY OF UNPUBLISHED DATA:	Unpublished data can be made available on a fee (contract) basis.
CONTACT:	Sandra King (202) 523-1309

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Industry Wage Survey: Nursing Homes**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
x		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Bureau of Labor Statistics (BLS)

TITLE: **Industry Wage Survey: Nursing Homes**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	Metro area		Metro area
Smallest unit	Metro area		Metro area
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **Annual Tuberculosis Statistical Summary**

Project Director: Alan B. Bloch, M.D.
Chief, Statistics and Analysis Section
Division of Tuberculosis Control
Centers for Disease Control
Atlanta, GA 30333

PURPOSE: Collect aggregate tuberculosis data from states and large cities (250,000 or more population) including demographic and clinical data.

DESIGN: Universe is all reported cases of tuberculosis since 1962, continuing yearly.

CONTENT: Demographic, clinical, and epidemiologic data in aggregate form for states and large cities.

YEARS OF DATA COLLECTION: Annually since 1962.

PUBLICATIONS: Tuberculosis Statistics: States and Cities, Centers for Disease Control, annual reports.
Tuberculosis in the United States: Centers for Disease Control, annual reports.

AVAILABILITY OF UNPUBLISHED DATA: Unpublished tabulations available from the Division of Tuberculosis Control.

CONTACT: Marion Meador
CDC
(404) 329-2512

SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **Annual Tuberculosis Statistical Summary**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
x		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions*
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Clinical Data
x		Epidemiologic Data

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* Tuberculosis

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SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **Annual Tuberculosis Statistical Summary**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Universe	
Under 65	Universe	
65+	Universe	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State		State
Smallest unit	Large city (≥ 250,000)		Large city (≥ 250,000)
Age classes			
Single years			
60-64			
65+	x		
65-74, 75-84, 85+			
Other			

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SPONSOR:	Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)
TITLE:	**National Immunization Survey—CPS Supplement**
	Project Director: Don Eddins Chief, Data Management Branch Division of Immunization Centers for Disease Control Atlanta, GA 30333
PURPOSE:	To monitor the immunization status for selected groups of the U.S. population.
DESIGN:	Supplement to the Current Population Survey of the Bureau of the Census.
CONTENT:	Immunization histories of household respondents are obtained. Questionnaire content has varied from time to time over the years. Survey is conducted in September.
YEARS OF DATA COLLECTION:	1959-84; budgeted for 1985; release date is July 1986.
PUBLICATIONS:	Data are published by the CDC through 1978. Since then, information has been published in various proceedings of the annual immunization conference.
AVAILABILITY OF UNPUBLISHED DATA:	Unpublished data are available from 1979 to present through the Division of Immunization. Public use tapes are also available.
CONTACT:	Don Eddins (404) 329-1875

SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **National Immunization Survey--CPS Supplement**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	Immunization status

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SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **National Immunization Survey—CPS Supplement**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	152,000	4.0%
65+	18,000	3.5%

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	SMSA	SMSA	SMSA
Age classes			
Single years			
60-64			
65+	x	x	x

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SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **Report of Verified Case of Tuberculosis**

Project Director:
Alan B. Bloch, M.D.
Chief, Statistics and Analysis Section
Division of Tuberculosis Control
Centers for Disease Control
Atlanta, GA 30333

PURPOSE: Collect detailed demographic, clinical, and epidemiologic data on individual cases of tuberculosis reported in the United States.

DESIGN: Universe is all reported cases of tuberculosis in the United States since 1985, continuing yearly.

CONTENT: Demographic, clinical, and epidemiologic data on individual cases of tuberculosis, collected annually.

YEARS OF DATA: Annually since 1985.

PUBLICATIONS: Tuberculosis Statistics: States and Cities, Centers for Disease Control, annual reports.
Tuberculosis in the United States, Centers for Disease Control, annual reports.

AVAILABILITY OF UNPUBLISHED DATA: Unpublished tabulations available from the Division of Tuberculosis Control.

CONTACT:
Marion Meador
CDC
(404) 329-2512

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SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **Report of Verified Case of Tuberculosis**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
x		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions*
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Clinical data
x		Epidemiologic data

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* Tuberculosis

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SPONSOR: Centers for Disease Control (CDC), Department of Health and Human Services (DHHS)

TITLE: **Report of Verified Case of Tuberculosis**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Universe	
Under 65	Universe	
65-74	Universe	
75-84	Universe	
85+	Universe	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State		State
Smallest unit	Zip code		City
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Robert Wood Johnson Foundation

TITLE: **Community Hospital Program (CHP) Access Impact Evaluation Surveys, 1978-79, 1981**

CONTRACTOR: Center for Health Administration Studies, University of Chicago

Project Director:
Ronald M. Andersen
Professor and Director
and
Lu Ann Aday
Associate Director for Research
Center for Health Administration Studies
University of Chicago
5720 South Woodlawn Avenue
Chicago, IL 60637

PURPOSE: The purpose of this study was to evaluate the access impact of the Robert Wood Johnson Foundation Community Hospital Program (CHP) group practices through baseline (1978-1979) and follow-up (1981) surveys of the communities and patients served by the groups.

DESIGN: The universe involved community residents and CHP patients in 12 selected study communities at 2 points in time--1978-1979 and 1981.

The sample consists of 10,578 cases at the first time period and 9,216 at the second. The sample design consisted of an area probability sample of the CHP's service area and a simple random sample of patients who had been to the site at the time of the baseline and follow-up surveys.

CONTENT: Data consist of general demographics, general medical and insurance information, and an extensive detailing of the respondent's experiences with health professionals during the year.

YEARS OF DATA COLLECTION: 1978, 1979, and 1981.

PUBLICATIONS: Aday, L.A., R. Andersen, S.S. Loevy, and B. Kremer, 1985. Hospital-Physician Sponsored Primary Care: Marketing and Impact. Health Administration Press, Ann Arbor, MI.

Aday, L.A., R. Andersen, G.V. Fleming, G. Chiu, V. Daughety, and M.J. Banks, 1978. "Overview of a Design to Evaluate the Impact of Community Hospital Sponsored Primary Care Group Practices." Medical Group Management 25 (September/ October): 42-46.

Aday, L.A., and R. Andersen, 1981. "Equity of Access to Medical Care: A Conceptual and Empirical Overview." Medical Care 19 (December Supplement): 4-27.

SPONSOR: Robert Wood Johnson Foundation

TITLE: **Community Hospital Program (CHP) Access Impact Evaluation Surveys, 1978-79, 1981**

PUBLICATIONS: Aday, L.A., C. Sellers, and R. Andersen, 1981. "Potentials of Local Health Surveys: A State-of-the-Art Summary." American Journal of Public Health 71 (August): 835-840.

Aday, L.A., and R. Andersen, 1983. "Equity of Access to Medical Care: A Conceptual and Empirical Overview." In Securing Access to Health Care: The Ethical Implications of Differences in the Availability of Health Services. Volume III: Appendices--Empirical, Legal, and Conceptual Studies. Washington, D.C.: President's Commission for Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Loevy, S.S., R. Andersen, and L.A. Aday, 1983. "Potential Patients and Loyal Users: Access to Care in Community Hospital Sponsored Group Practices." Journal of Ambulatory Care Management 6 (November): 43-57.

Aday, L.A., R. Andersen, S.S. Loevy, and B. Kremer, 1984. "Hospital Sponsored Primary Care: Impact on Patient Access." American Journal of Public Health 74 (August): 792-798.

Aday, L.A., 1984. "Exploring Frontiers of Rural Health: Access Impact Evaluation of Community Hospital-Affiliated Medical Groups in Two Rural Communities." Accepted for presentation at American Rural Health Association Institute meetings, Orlando, Florida, June 5-8, 1984.

Andersen, R., L.A. Aday, and G.V. Fleming, 1984. "A Tale of Two Surveys: Lessons from the Best and Worst of Times in Program Evaluation." Paper presented at NSF Conference on Improving Data Collection in Program Evaluation, Amherst, Massachusetts, March 29-31, 1984.

AVAILABILITY OF UNPUBLISHED DATA: Data tapes are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

CONTACT: Lu Ann Aday or Christopher Lyttle
Center for Health Administration Studies
(312) 962-7753

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SPONSOR: Robert Wood Johnson Foundation

TITLE: **Community Hospital Program (CHP) Access Impact Evaluation Surveys, 1978-79, 1981**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations: of activity of mobility
		Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
x	x	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Robert Wood Johnson Foundation

TITLE: **Community Hospital Program (CHP) Access Impact Evaluation Surveys, 1978-79, 1981**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not available	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	City	City	City
Smallest unit	Area code	Area code	
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSORS: Robert Wood Johnson Foundation and Health Care Financing Administration (HCFA)

TITLE: **Municipal Health Services Program (MHSP) Evaluation**

CONTRACTOR: Center for Health Administration Studies, University of Chicago

Project Director:
Gretchen V. Fleming
Co-Principal Investigator and
Study Director
Center for Health Administration Studies
University of Chicago
5720 South Woodlawn Avenue
Chicago, IL 60637

PURPOSE: This study was established to evaluate the impact on expenditures for medical care of the MHSP primary health care centers through baseline (1979-1980) and follow-up (1980-1981) surveys of the communities and patients served.

DESIGN: The universe consists of individuals in households with phones and living in the MHSP centers' service areas. The sample was constructed through random-digit dialing including an oversample of patients from the MHSP centers. The sample consists of 16,366 cases (a 72% response rate) for the baseline, and 13,271 cases (a 73% response rate) for the follow-up.

CONTENT: The information collected consists of general demographics and extensive information on access to and cost of medical care delivery in the preceding year.

YEARS OF DATA COLLECTION: Data collected in two waves covering 1979-80 and 1980-81. No further follow-ups are planned.

PUBLICATIONS: "Imputation of Income: A Procedural Comparison," Timothy F. Champney and Ralph Bell, Proceedings of the Section on Survey Research Methods, American Statistical Association, Washington, D.C., August 1982.

"Evaluating the Municipal Health Services Program," Ronald Andersen, Gretchen V. Fleming, Lu Ann Aday, Sandra Z. Lewis, Louise A. Bertsche, and Martha J.Banks, Annals of the New York Academy of Science, 1982.

"Improving the Provision of Ambulatory Care by City Government: Preliminary Findings from the Municipal Health Program," Charles Brecher, Ronald Andersen, Edith Davis, Gretchen V. Fleming, and Miriam Ostow. In Stuart H. Altman et al. (eds.), Ambulatory Care, Lexington Books, Lexington, MA 1983.

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SPONSOR: Robert Wood Johnson Foundation and Health Care Financing Administration (HCFA)

TITLE: **Municipal Health Services Program (MHSP) Evaluation**

"Item Nonresponse in Telephone Surveys: Analysis of Who Fails to Report Income," Ralph Bell, *Social Science Quarterly*, Vol. 65, No. 1, March 1984, pp. 207-215.

"The Municipal Health Services Program: Improving Medical Care Access While Containing Expenditures," Fleming, Gretchen V. and Andersen, Ronald M. Paper presented at the annual meeting of the American Public Health Association, Anaheim, CA, November 14, 1984.

"A Tale of Two Surveys: Lessons From the Best and Worst of Times in Program Evaluation," Ronald M. Andersen, Lu Ann Aday, Gretchen V. Fleming. In *Collecting Evaluation Data: Problems and Solutions*, Sage Publishing Company, to be published 1986.

AVAILABILITY OF UNPUBLISHED DATA: Data only available through the Center for Health Administration Studies.

CONTACT:

Gretchen V. Fleming
Center for Health Administration Studies
(312) 981-7633

Christopher S. Lyttle
Center for Health Administration Studies
(312) 962-7753

Tony Hausner
HCFA
(301) 597-2366

SPONSOR: Robert Wood Johnson Foundation and Health Care Financing Administration (HCFA)

TITLE: **Municipal Health Services Program (MHSP) Evaluation**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
x		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
x		Out-of-pocket costs
x		Medicare
x		Medicaid
x		State expenditures
x		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
x		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSORS: Robert Wood Johnson Foundation and Health Care Financing Administration (HCFA)

TITLE: **Municipal Health Services Program (MHSP) Evaluation**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	See Design	
Under 65		
65+	Approx. 1,400 in household component	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit	Service area		Service area
Smallest unit	Telephone exchange		Telephone exchange
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Robert Wood Johnson Foundation

TITLE: **National Survey of Access to Medical Care, 1982**

CONTRACTOR: Center for Health Administration Studies,
University of Chicago

Project Director: Ronald M. Andersen
Professor and Director
Graduate School of Business
University of Chicago
5720 South Woodlawn Avenue
Chicago, IL 60637

PURPOSE: The purpose of this study was to provide current data on access to medical care for the U.S. population.

DESIGN: The universe was all U.S. households with phones. The sample design represented a random-digit dialing sample of U.S. households with phones, including an oversample of low income (150% of poverty line) households. The sample consists of 6,610 cases.

CONTENT: Data consists of general demographics, general medical and insurance information, and many items on access to health care during the year prior to the interview. The health care items include descriptions of and satisfaction with: usual source of care, most recent visit to a doctor, most recent medical emergency, and most recent hospital stay.

YEARS OF DATA COLLECTION: 1982.

PUBLICATIONS: Aday, L.A., et al., 1985. Access to Medical Care In the U.S.: Who Has It, Who Doesn't.

Lou Harris & Associates, 1982. Access to Health Care in the U.S.: 1982. New York: Lou Harris & Associates.

Robert Wood Johnson Foundation, 1983. Updated Report on Access to Health Care for the American People. Special Report Number One. Princeton, New Jersey: Robert Wood Johnson Foundation.

AVAILABILITY OF UNPUBLISHED DATA: Data tapes (ICPSR 8244) are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

Raw file with documentation has been provided to ICPSR.

CONTACT: Lu Ann Aday or Christopher Lyttle
Center for Health Administration Studies
(312) 962-7753

SPONSOR: Robert Wood Johnson Foundation

TITLE: **National Survey of Access to Medical Care, 1982**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
x	x	Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations: of activity of mobility
		Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
x	x	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

377

SPONSOR: Robert Wood Johnson Foundation

TITLE: **National Survey of Access to Medical Care, 1982**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	6,610	
Under 65	5,538	
65-74	700	
75-84	314	
85+	58	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	U.S.	U.S.	U.S.
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: Commission on Professional and Hospital Activities

TITLE: **Commission on Professional and Hospital Activities (CPHA) Data Tapes**

Project Director:
Carol Prevost, Research Associate
Research Services
Commission on Professional and Hospital Activities
1968 Green Road
P.O. Box 1809
Ann Arbor, MI 48106

PURPOSE: Study of medical record abstracts for discharges from nonfederal, short-term, general, acute care hospitals for administrative and research uses.

DESIGN: Data on discharges are obtained from about 1,600 subscriber hospitals to the Professional Activity Study, for about 12 million patient discharges annually in the United States and Canada, or about 26% of the nonfederal, short-term general hospital discharges in the United States and about 22% in Canada. Annually, 2 million discharge abstracts are selected systematically from the U.S. records and projected by hospital bed-size, census divisions (9), and urban/rural location to match the distribution of hospitals by these characteristics found in the American Hospital Association's Annual Survey of Hospitals data tape.

CONTENT: A series of tapes has been created:

(1) Length of stay by diagnosis related groups (DRGs), 9 census divisions, urban/rural location of hospital.

(2) Length of stay by DRGs for Medicare patients, 9 census divisions, urban/rural--identical to tape 1 except that only records with Medicare checked as principal source of payment are used.

(3) Annual trend by DRG--displays the changing frequencies of discharges by DRGs on an annual basis for 1976-1980. The data are listed by each of the 9 census divisions and hospital bed-size.

(4) Hospital and patient characteristics file by ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical Modification)--frequencies of discharges based on patient and hospital characteristics by discharge diagnosis.

(5) Hospital and patient characteristics by DRG--within each DRG the number of discharges are further divided by age, sex, race, length of stay, and discharge status. The data also contain variables such as bed-size and region.

SPONSOR: Commission on Professional and Hospital Activities

TITLE: Commission on Professional and Hospital Activities (CPHA) Data Tapes

From the completed tape (12 million records annually) 2 tapes are created:

(6) Length of stay by region, by diagnosis, and by operation for List A (398 diagnoses) and List B (264 procedure codes).

(7) Case fatality rate by DRG. Shows the number of discharges by DRGs and percentage of fatalities separately for all discharges and for Medicare discharges.

From a tape of 3 million discharge records for 1976-80 for hospitals that also report inpatient total charge data, weights have been created to relate diagnosis and procedures to charges. These are contained in the tape:

(8) Resource intensity weights by List A and B.

YEARS OF DATA COLLECTION: The Professional Activity Study was begun in 1955 and is an ongoing collection of medical abstracts from subscribing hospitals in the United States and Canada.

PUBLICATIONS: A series of volumes entitled "Length of Stay"--by diagnosis, by region, by operation by region--was published beginning in 1963 and is continuing annually. The latest year released is 1983.

AVAILABILITY OF UNPUBLISHED DATA: The tapes identified under Content are available for purchase for the following years:

(1) 1979, 1980, 1981, 1982, 1983.
(2) 1983.
(3) 1980-83.
(4) 1983.
(5) 1983.
(6) 1979, 1980, 1981, 1982, 1983.
(7) 1983.
(8) 1976-80 combined.

CONTACT:
Jean Baer
CPHA
(800) 521-6210

SPONSOR: Commission on Professional and Hospital Activities

TITLE: **Commission on Professional and Hospital Activities (CPHA) Data Tapes**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
*		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Mortality by Hospital Volume

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* See Content

SPONSOR: Commission on Professional and Hospital Activities

TITLE: **Commission on Professional and Hospital Activities (CPHA) Data Tapes**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Annual Sample	Nonresponse Rate
Total	12 million records	
Under 65*		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit		U.S.	
Smallest unit		Census division	
Age classes			
Single years			
60-64			
65+		x	
65-74, 75-84, 85+			
Other			

SPONSOR: Consumer Product Safety Commission

TITLE: National Electronic Injury Surveillance System (NEISS)

Project Director:
Directorate for Epidemiology
Data released through:
Nancy S. Johnston, Director
National Injury Information
Clearinghouse, Room 625
Consumer Product Safety Commission
5401 Westbard Avenue
Washington, DC 20207

PURPOSE: To provide national estimates of number and severity of injuries associated with consumer products and to provide a means of locating injury victims for further information on causal factors.

DESIGN: Universe consists of entire United States and territories. NEISS is based on a probability sample of hospitals with emergency rooms by size (emergency visits per day) from which a national estimate of injuries treated in hospital emergency departments is projected. The basic factor by which a case is inflated to derive national estimates is the inverse of the probability of selection of the hospital that treats that case. A nonresponse factor is also incorporated to adjust for hospitals not reporting cases for any given month.

CONTENT: Information collected through NEISS includes:

(1) Date of treatment
(2) Age of patient
(3) Sex of patient
(4) Injury diagnosis/body part
(5) Disposition
(6) Two product codes
(7) Third product or child-resistant closure involvement
(8) Accident locale
(9) Fire or motor vehicle involvement
(10) Remarks/comments

YEARS OF DATA COLLECTION: NEISS began operation in July 1972. NEISS redesign occurred in October 1978, and hospitals in the sample were phased in and out during the next year. Data are available in standard formats on an annual basis but are not necessarily comparable between the two sample periods.

PUBLICATIONS: NEISS Data Highlights is published on an annual basis.

AVAILABILITY OF UNPUBLISHED DATA: Specific product-associated data may be requested on an individual basis from the National Injury Information Clearinghouse, Directorate for Epidemiology, U.S. Consumer Product Safety Commission, Room 625, 5401 Westbard Avenue, Washington, DC 20207. Telephone (301) 492-6424.

CONTACT: Nancy S. Johnston (301) 492-6424

SPONSOR: Consumer Product Safety Commission

TITLE: National Electronic Injury Surveillance System (NEISS)

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: Consumer Product Safety Commission

TITLE: **National Electronic Injury Surveillance System (NEISS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
	x	Product-specific accidental injury

SPONSOR: Department of Agriculture (USDA)

TITLE: **Nationwide Food Consumption Survey 1977-78**

Project Director:
Robert L. Rizek, Director
Nutrition Monitoring Division
Human Nutrition Information Service
U.S. Department of Agriculture
6505 Belcrest Road, Room 368
Hyattsville, MD 20782

PURPOSE: The survey is designed to provide basic data on current food consumption patterns and on the nutritional quality of dietary intakes by the U.S. population. The data are used for administering public programs affecting food supply, safety, distribution, and consumption; planning food assistance and educational programs to improve dietary practices; and providing baseline data for research.

DESIGN: The Nationwide Food Consumption Survey 1977-78 was collected from 14,930 households of 1 or more persons. The households were from a statistically selected sample of all private households in the 48 conterminous states, stratified by region, urbanization, and geographic or demographic similarities. Separate samples were drawn for each quarter in the period April 1977-March 1978.

Supplemental surveys were conducted in Alaska, Hawaii, and Puerto Rico and among the elderly and those households eligible for food stamps. A follow-up of the latter was conducted in 1979-80 to determine the effects of changes in the food stamp program.

CONTENT: For each household data were collected on household food used at home during the previous 7 days along with information on characteristics of the household that might be related to food consumption: home food production; the previous year's household income before taxes; participation in food programs; education, occupation, and employment status of the male and female heads of household; and household size and composition.

For individuals in the households, data are collected about each item of food consumed: a detailed description of the item; amount consumed; when, with whom consumed; type of service and amount paid for food purchased and consumed away from home. Data were collected for a 3-day period in all surveys except the elderly survey and the follow-up survey of low-income households, for which data were collected for 1 day.

YEARS OF DATA COLLECTION: Food consumption surveys have been conducted in 1936-37, 1942, 1948 (urban sample only), 1955, 1965-66, 1977-78, and 1979-80 (2-year follow-up survey of low-income households). Only the most recent surveys (1965-66, 1977-78, 1979-80) contain data on individual dietary intakes.

SPONSOR: Department of Agriculture (USDA)

TITLE: **Nationwide Food Consumption Survey 1977-78**

PUBLICATIONS: Final reports have been published for 1977-78 for food consumption by household, region, and season; also for dietary levels by household, region, and season. Reports and a complete list of titles are available from contact person.

AVAILABILITY OF UNPUBLISHED DATA: Data tapes are available through the National Technical Information Service (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161.

Data for elderly are in two tapes:

Elderly Household Food Consumption Survey, 1977-78
PB83-137281

Elderly Individual Food Intake Survey, 1977-78
PB83-134023

CONTACT: Robert B. Reese or Sharon J. Mickle
USDA
(301) 436-8485

SPONSOR: Department of Agriculture (USDA)

TITLE: **Nationwide Food Consumption Survey 1977-78**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	**Food consumption**

SPONSOR: Department of Agriculture (USDA)

TITLE: **Nationwide Food Consumption Survey 1977-78**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Unweighted Number in Sample	Nonresponse Rate
Total	30,770	
Under 65	27,735	
65-74	1,958	
75-84	887	
85+	190	

SIZE OF SAMPLE

	UNWEIGHTED NUMBER IN SAMPLE			
Age	Elderly	Low Income	Low Income Follow-up	Puerto Rico
Total	8,036	12,847	8,492	7,950
under 65	1,923	11,267	7,482	7,245
65-74	3,780	986	597	435
75-84	1,865	486	353	202
85+	468	108	60	68

Age	Alaska	Hawaii
Total	2,393	3,086
under 65	2,348	2,793
65-74	35	218
75-84	8	63
85+	2	12

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit	48 conterminous states	(same as data files)	48 conterminous states
Smallest unit	9 Census divisions		4 Census regions
Age classes	x		
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			65-74, 75+

SPONSOR: Department of Housing and Urban Development (HUD)

TITLE: **American Housing Survey (AHS)**

Project Director:
Duane T. McGough, Division Director
Division of Housing and Demographic Analysis
Office of Policy Development and Research
Office of Economic Affairs
U.S. Department of Housing and Urban Development
451 Seventh Street, SW
Washington, DC 20410

PURPOSE: The primary purpose of the AHS is to provide a current and ongoing series of data on the size, state, and composition of the nation's housing and its occupants.

DESIGN: The current basic national AHS sample is 47,000 housing units chosen from the 1980 Census.

There are 44 metropolitan sample (MS) areas with a sample size for each MS of 4,250 or 8,500 housing units. The 44 metropolitan areas are covered over a four-year cycle, i.e., 11 areas are interviewed each year.

The AHS is a longitudinal sample. Addresses remain in the sample and are eliminated only in the event of a redesign or sample reduction. An all-new sample was selected for the 1985 AHS-National; however, it can be linked with the 1980 census.

CONTENT: Type and age of dwelling, size, facilities, condition of dwelling, previous residence; cost of home, method of payment, income of occupant; 1985 energy supplement; 1985 second-home supplement.

YEARS OF DATA COLLECTION: National Sample:

Annually 1973-81; biannually 1983-85 and future years.

Metro Sample:

1974-76	60 SMSAs	(20 SMSAs each year for 3 years);
1977-80	60 SMSAs	(15 SMSAs each year for 4 years);
1981-84	44 SMSAs	(11 SMSAs each year for 4 years);
1985-88	44 SMSAs	(11 SMSAs each year for 4 years).

SPONSOR: Department of Housing and Urban Development (HUD)

TITLE: **American Housing Survey (AHS)**

PUBLICATIONS: National AHS--1985 available beginning December 1986; last volume by October 1987:

(A) General Housing Characteristics for the United States and Regions;
(B) Indicators of Housing and Neighborhood Quality by Financial Characteristics for the United States and Regions;
(C) Financial Characteristics of the Housing Inventory for the United States and Regions;
(D) Housing Characteristics of Recent Movers for the United States and Regions;
(E) Urban and Rural Housing Characteristics for the United States and Regions;
(F) Energy-Related Housing Characteristics for the United States and Regions.

Metropolitan AHS-1985. One volume for each metropolitan area, May 1987 through August 1987.

AVAILABILITY OF UNPUBLISHED DATA:
National: AHS--1985 micro data tape--April 1987;
Metropolitan: AHS--1985 micro data tape--January 1987.

CONTACT:
Iredia B. Irby
HUD
(202) 755-5060

SPONSOR: Department of Housing and Urban Development (HUD)

TITLE: **American Housing Survey (AHS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
x		Migration or mobility
		VITAL STATISTICS
x		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Department of Housing and Urban Development (HUD)

TITLE: **American Housing Survey (AHS)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of Units in Sample	Nonresponse Rate
Total	Natl: 47,000 Metro: 68,000	3.3%

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Not applicable		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: Department of Labor

TITLE: **National Longitudinal Surveys of Labor Market Experience of Older Men (Parnes Survey)**

CONTRACTOR: Center for Human Resource Research, Ohio State University

Project Director: Kenneth I. Wolpin, Director
Center for Human Resource Research
Ohio State University
650 Ackerman Road, Suite A
Columbus, OH 43202-1501

PURPOSE: To study labor market problems and experiences of middle-aged and older men as they move toward and into retirement.

DESIGN: Stratified probability sample representative of U.S. civilian population of males ages 45-59 in 1966, with an oversampling of blacks. Original sample n = 5020. Number interviewed in 1983 = 2633 (52.5%). Of original number, 29.8% were deceased and 17.7% disappeared from sample for other reasons.

CONTENT: Abbreviated lifetime employment experience prior to initial survey; detailed employment experience 1966-1983; self-reported health limitations affecting work; attitudes toward jobs and toward work in general; income (by source) and assets; detailed family composition record.

The National Longitudinal Surveys Handbook, published by the Center for Human Resource Research, Ohio State University, annually shows a detailed list of variables and years in which each was collected.

YEARS OF DATA COLLECTION: Face-to-face personal interviews: 1966, 1967, 1969, 1971, 1976, 1981.

Mail questionnaire: 1968.
Telephone interviews: 1973, 1975, 1978, 1980, 1983.
No further interviews contemplated.

Data through 1983 currently available.

PUBLICATIONS: See Sproat, Kezia, *The National Longitudinal Surveys of Labor Market Experience: An Annotated Bibliography of Research*. Lexington, Mass: Lexington Books, 1985.

SPONSOR:	Department of Labor
TITLE:	**National Longitudinal Surveys of Labor Market Experience of Older Men (Parnes Survey)**
AVAILABILITY OF UNPUBLISHED DATA:	Public-use data tape available from NLS Users' Office, Center for Human Resource Research, Coordinator of NLS Users' Office, 650 Ackerman Road, Suite A, Columbus, OH, 43202-1501. Telephone: (614) 263-1682. Data tapes (ICPSR 7610) are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.
CONTACT:	Coordinator of the NLS Users' Office (614) 263-1682.

SPONSOR: Department of Labor

TITLE: **National Longitudinal Surveys of Labor Market Experience of Older Men (Parnes Survey)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
males only		Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
x	x	Natality
x	x	Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
		Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
1976, 1981	1976, 1981	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
1981	1981	Social interaction
1976, 1981	1976, 1981	Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Department of Labor

TITLE: **National Longitudinal Surveys of Labor Market Experience of Older Men (Parnes Survey)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Following data are for 1981:

Age	Number in Sample*	Nonresponse Rate
Total	3,639	23%
Under 65	1,483	24%
65-74	2,156	23%
75-84		
85+		

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* Eligible for interview from original sample (i.e., excluding deceased)

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.	*		
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	
Smallest unit	Census div.	Census div.	
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			65-69; 70-75

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* Census Bureau has SSN.

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SPONSOR: Duke University, Center for the Study of Aging and Human Development

TITLE: **Durham Older Americans Resources and Services (OARS) Community Survey**

Project Director: Linda K. George
Director, Data Archive
Box 3003
Duke University Medical Center
Durham, NC 27710

PURPOSE: The original study (1972-73) was intended to (1) assess the functional status of a representative sample of older persons residing in the community and (2) develop a methodology (the OARS methodology) for assessing the multi-dimensional functional status of older persons. The purposes of the longitudinal follow-ups (1974, 1975) were to (1) determine the validity and reliability of the OARS methodology and (2) monitor changes in functional status over time.

DESIGN: The study is a cross-sectional survey consisting of personal interviews, with a longitudinal follow-up of a subsample. The Durham OARS Community Survey consists of 4 test dates. The sample first tested during 1972-73 included 997 respondents and comprised a 1-in-10 random stratified area probability sample of Durham County, N.C. A randomly drawn subsample, with specified kinds and numbers of impairments, was chosen for a validation study. This subsample was examined in both 1974 (n = 120) and 1975 (n = 116). Later in 1975, a one-third random sample of the initial group was resurveyed, using a shorter telephone survey.

CONTENT: Two major content areas are functional status and service utilization. Functional status is viewed as having 5 distinct components: social resources, economic resources, physical health, mental health, and activities of daily living (self-care capacity). Multiple indicators of each dimension were included in the surveys. Questions about services focused on the perceived need and actual utilization of generic types of services. This study was instrumental in developing the OARS methodology, which has continued to be used in current major studies of the well-being of older people.

YEARS OF DATA COLLECTION: The original study was conducted in 1972-73, with follow-up in 1974, 1975, and later in 1975.

SPONSOR:	Duke University, Center for the Study of Aging and Human Development
TITLE:	**Durham Older Americans Resources and Services (OARS) Community Survey**
PUBLICATIONS:	Duke University Center for the Study of Aging and Human Development. Multidimensional Functional Assessment: The OARS Methodology, A Manual. Durham, N.C.: Center for the Study of Aging and Human Development, 1978. Linda K. George, Richard Landerman, and Gerda G. Fillenbaum. Developing Measures of Functional Status and Service Utilization: Refining and Extending the OARS Methodology. Durham, N.C.: Center for the Study of Aging and Human Development, 1982. L.K. George and G.G. Fillenbaum. OARS methodology: A decade of experience in geriatric assessment. Journal of the American Geriatrics Society, 1985, 33:607-615.
AVAILABILITY OF UNPUBLISHED DATA:	All four community surveys are on a single data tape with documentation contained in a codebook. The data are available in either EBCDIC or SPSS format.
CONTACT:	Linda K. George (919) 684-3204

SPONSOR: Duke University, Center for the Study of Aging and Human Development

TITLE: **Durham Older Americans Resources and Services (OARS) Community Survey**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
		Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
x	x	SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
x	x	Community-based resources
x	x	Health professions
x	x	Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x	x	Cognitive impairment scale
		Behavior problems
x	x	Depression
x	x	Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x	x	Morbidity
x	x	Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
x	x	Rehabilitation
x	x	Mental health hospitalization
x	x	Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
x	x	Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Duke University, Center for the Study of Aging and Human Development

TITLE: **Durham Older Americans Resources and Services (OARS) Community Survey**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	997	
Under 65		
65+	997	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	County (Durham)	County	
Smallest unit			
Age classes			
Single years			
60-64			
65+	x	x	
65-74, 75-84, 85+			
Other			

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SPONSORS:	Employee Benefit Research Institute and the Department of Health and Human Services (1983) Department of Labor and Social Security Administration (1979) Departments of Treasury, Labor, and Health, Education, and Welfare (1972)
TITLE:	**Survey of Pension and Retirement Plan Coverage, 1972, 1979, 1983**
CONTRACTOR:	All three surveys were conducted by the Bureau of Census. Project Director: See staffing described in Publications.
PURPOSE:	1972: To estimate retirement plan coverage for persons working full-time in private industry. 1979: To estimate retirement plan coverage for all civilian workers provided by employer- or union-sponsored plans, individual retirement accounts for noncovered workers, and Keogh plans. 1983: To add to 1979 coverage universal individual retirement accounts and 401(K) plans.
DESIGN:	1972: The survey questions were added for half of the sample households in the April 1972 Current Population Survey (CPS). 1979: The survey was linked to the May CPS, the May and June earnings survey, and the March income supplement. 1983: The survey was linked to the May CPS, the May and June earnings supplement, and the March income supplement.
CONTENT:	1972: A question was added to the CPS: "Excluding social security, railroad retirement, and veterans' pensions, are you covered in your present full-time job by a pension or profit-sharing plan providing retirement benefits?" 1979: Coverage extended to all civilian workers and to employer- or union-sponsored plans. 1983: Coverage further extended to include universal individual retirement accounts and 401(K) plans.
YEARS OF DATA COLLECTION:	1972, 1979, 1983. No further plans for future surveys.
PUBLICATIONS:	1972: *Coverage and Vesting of Full-Time Employees Under Private Retirement Plans*. September 1973, Department of Health, Education and Welfare, Social Security Administration. DHEW Pub. No. SSA 74-11908 and Department of Labor, Bureau of Labor Statistics, BLS Report No. 423.

SPONSORS:	Employee Benefit Research Institute and the Department of Health and Human Services (1983) Department of Labor and Social Security Administration (1979) Departments of Treasury, Labor, and Health, Education, and Welfare (1972)
TITLE:	**Survey of Pension and Retirement Plan Coverage, 1972, 1979, 1983**
PUBLICATIONS:	1979: Daniel J. Beller, "Coverage Patterns of Full-Time Employees Under Private Retirement Plans." *Social Security Bulletin* (July 1981): 3-11. Gayle Thompson Rogers, "Vesting of Private Pension Benefits in 1979 and Changes from 1972." *Social Security Bulletin* (July 1981): 12-29. 1983: Employee Benefit Research Institute Publications: *Issue Brief*, Nos. 32 and 33. E.S. Andrews, *The Changing Profile of Pensions in America*. Washington, D.C.: Employee Benefit Research Institute, 1985.
AVAILABILITY OF UNPUBLISHED DATA:	Data Users Service Division, Bureau of the Census, Washington, DC 20233.
CONTACT:	Mona Seliger Employee Benefit Research Institute 2121 K Street, NW Washington, DC 20037 (202) 463-8148

SPONSOR: Employee Benefit Research Institute and the Department of Health and Human Services (1983)

TITLE: **Survey of Pension and Retirement Plan Coverage, 1972, 1979, 1983**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
		Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x	x	Marriage
		Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	Pension Coverage

SPONSOR: Employee Benefit Research Institute and the Department of Health and Human Services (1983)

TITLE: **Survey of Pension and Retirement Plan Coverage, 1972, 1979, 1983**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Year	Number in Sample	Nonresponse Rate
1983	32,535	11.5%
1979	30,000	15%
1972	15,000	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	
Smallest unit	SMSA	SMSA	
Age classes			
Single years	x	x	
60-64	x	x	
65+	x	x	
65-74, 75-84, 85+	x	x	
Other			

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SPONSOR: Food and Drug Administration (FDA), Department of Health and Human Services (DHHS)

TITLE: **Dietary Supplements Survey**

Project Director:
Raymond E. Schucker, Staff Advisor
Office of Nutrition
Division of Consumer Studies
Food and Drug Administration
200 C Street, SW
Washington, DC 20204

PURPOSE: Data were collected to provide quantitative estimates of nutrient intake from vitamin and mineral supplements for the U.S. population.

DESIGN: Data were collected by telephone interviews from a representative sample of telephone households (n = 2,991). An eligible respondent (adult age 16 or over) was randomly selected and interviewed. Sample was stratified by age (16-24, 25-64, 65 and over) with approximately equal n in each strata. Nonresponse rate was approximately 24%. Quantitative intake section of questionnaire is being replicated in 1986 National Health Interview Survey.

CONTENT: Information collected consists of quantitative reports of vitamin and mineral supplement use, purchase characteristics, influence sources, health attitudes and behavior, and demographics.

YEARS OF DATA COLLECTION: Survey was conducted in 1980. Quantitative intake section is being replicated in the 1986 National Health Interview Survey.

PUBLICATIONS: Long, A.S. and Schucker, R.E., Attitude and Lifestyle Profiles of Behaviorally Defined Segments of Dietary Supplement Users. Unpublished. Food and Drug Administration, Washington, D.C.

Stewart, M.L., McDonald, J.T., Levy, A.S., Schucker, R.E., and Henderson, D.P. Vitamin/Mineral Supplement Use: A Telephone Survey of U.S. Adults (in press).

AVAILABILITY OF UNPUBLISHED DATA: Certain data are available from NTIS. Data tapes are not currently available to public. For more information contact Dr. Alan S. Levy.

CONTACT:
Alan S. Levy
Division of Consumer Studies
HFF-240
Food and Drug Administration
200 C Street, SW
Washington, DC 20204
(202) 472-2048

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SPONSOR: Food and Drug Administration (FDA), Department of Health and Human Services (DHHS)

TITLE: **Dietary Supplements Survey**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
x		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Dietary supplements

SPONSOR: Food and Drug Administration (FDA), Department of Health and Human Services (DHHS)

TITLE: **Dietary Supplements Survey**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Approx. 2,700	
Under 65	Approx. 1,800	
65+	Approx. 900	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+	x		
65-74, 75-84, 85+			
Other			

SPONSOR:	General Accounting Office (GAO)
TITLE:	**Nursing Home Data by State, 1976-80**
	Project Director: Susan Van Gelder, Assignment Manager Human Resources Division General Accounting Office 330 C Street, SW Washington, DC 20201
PURPOSE:	To examine trends in nursing home bed supply and Medicaid nursing home expenditures and utilization over a 5-year period.
DESIGN:	The universe was each state in the United States except Arizona. Data were collected for the period 1976-80 through a telephone and mail survey of Medicaid officials in 49 states and the District of Columbia. State-supplied data were combined with Medicaid expenditure data from the Health Care Financing Administration, and Census Bureau population data.
CONTENT:	Data were collected on several areas of nursing home care: licensed and Medicaid-certified nursing home beds, Medicaid and private pay patient days, Medicaid reimbursement rates, Medicaid skilled nursing facility and intermediate care facility expenditures, and other less quantitative variables in order to examine trends in supply and expenditures and to determine how these trends related to changing patient characteristics (a separate data base) and state reimbursement systems.
YEARS OF DATA COLLECTION:	Data collected in 1981-82 for the period 1976-80.
PUBLICATIONS:	"Medicaid and Nursing Home Care: Cost Increases and the Need for Services are Creating Problems for the States and the Elderly," GAO/IPE-84-1, October 21, 1983.
AVAILABILITY OF UNPUBLISHED DATA:	Not available.
CONTACT:	Susan Van Gelder (202) 426-5246

SPONSOR: General Accounting Office (GAO)

TITLE: **Nursing Home Data by State, 1976-80**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
x		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
x		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: General Accounting Office (GAO)

TITLE: **Nursing Home Data by State, 1976-80**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable Data aggregated by state	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S. (except AZ)		U.S. (except AZ)
Smallest unit	State		State
Age classes			
Single years			
60-64			
65+			x
65-74, 75-84, 85+	x		x
Other			

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Master Provider of Services File**

Project Director: Frank L. Kirby
Office of Statistics and Data Management
Bureau of Data Management and Strategy
Health Care Financing Administration
Room 1-F-2, Oak Meadows Building
6325 Security Boulevard
Baltimore, MD 21207

PURPOSE: To automate the provider certification activity.

DESIGN: All Medicare and Medicaid participating institutional providers.

CONTENT: Provider characteristics:

- Name and address
- Medicare provider number
- Staff size
- Bed size
- Services authorized
- Accreditation
- County, Metropolitan Statistical Area codes

The file is produced from the Medicare/Medicaid Automated Certification System (MMACS).

YEARS OF DATA COLLECTION: Reflects the Medicare recertification cycle--from one to three years depending on type of institution. Updated daily on a flow basis.

PUBLICATIONS: None.

AVAILABILITY OF UNPUBLISHED DATA: Current file available on magnetic tape or listing. Contact Office of Statistics and Data Management.

CONTACT: Frank L. Kirby
(301) 594-0942

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Master Provider of Services File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x	x	General hospitals
x	x	Private psychiatric hospitals
x	x	Public mental health hospitals
x	x	Nursing homes
x	x	Other institutional resources
x	x	Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY
		FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Master Provider of Services File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Not applicable		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Annual Summary: Person Summary File**

Project Director: David W. Champney
Computer Systems Analyst
Office of Statistics and Data Management
Bureau of Data Management and Strategy
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

PURPOSE: The summary file is used to produce statistical reports by age, sex, race, and state of residence, showing number of persons receiving reimbursed Medicare services and amounts reimbursed by type of service.

DESIGN: 5% sample of aged Medicare population based on Social Security number. 25% sample of disabled Medicare population based on Social Security number.

CONTENT: The file is based on bills for the sample population. It shows utilization, charges, and reimbursements by type of service for each person using reimbursed services.

YEARS OF DATA COLLECTION: This file is created annually after June 30, in its present form, beginning with data for 1978.

PUBLICATIONS: See Health Care Financing Administration Series Program Statistics. Reports in this series consist of detailed statistical data on the Medicare program.

AVAILABILITY OF UNPUBLISHED DATA: Tapes and tabulations for 1982 and 1983.

CONTACT: David W. Champney or Irving Goldstein
HCFA
(301) 594-6128 (301) 597-5980

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Annual Summary: Person Summary File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
x		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Annual Summary: Person Summary File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Annual Number of Persons in Sample*	Nonresponse Rate
Total	1,350,000	
Under 65	500,000 (disabled)	
65-74	500,000	
75-84	250,000	
85+	100,000	

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* approximate

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	Health service area		State, region, U.S.
Smallest unit	County		State
Age classes			
Single years			
60-64			x
65+			x
65-74, 75-84, 85+			x
Other *	x		x

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* Aged: 65-66, 67-68, 69-70, 71-72, 73-74, 65-69, 70-74, 75-79, 80-84; > 85.

Disabled: < 35, 35-44, 45-54, 55-59, 60-64

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SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)
TITLE:	**Medicare Enrollment File**
	Project Director: Mary P. Clifford Computer System Analyst Office of Statistics and Data Management Bureau of Data Management and Strategy Health Care Financing Administration Oak Meadows Building 6325 Security Boulevard Baltimore, MD 21207
PURPOSE:	To maintain information on the demographic and entitlement status of Medicare enrollees, used in the administration of the Medicare program.
DESIGN:	All Medicare enrollees.
CONTENT:	State and county of residence of Medicare enrollees and type of enrollment (i.e., Part A and/or Part B). Date of birth, sex, race.
YEARS OF DATA COLLECTION:	Continuous file beginning with inception of Medicare program, July 1, 1966.
PUBLICATIONS:	Annual Medicare Program Statistics, HCFA
AVAILABILITY OF UNPUBLISHED DATA:	Contact Irving Goldstein or Bob Butler.
CONTACT:	Irving Goldstein or Bob Butler HCFA (301) 597-5980 (301) 597-5986

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Enrollment File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Enrollment File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number enrolled in Medicare (approximate)	Nonresponse Rate
Total	29,000,000	
Under 65	3,000,000	
65-74	15,000,000	
75-84	8,000,000	
85+	2,500,000	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	Census region		Census region
Smallest unit	Zip code		County
Age classes			
Single years			
60-64			x
65+			x
65-74, 75-84, 85+			x
Other			

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **The Medicare History Sample—1974 and Later**

Project Director:
Michael McMullan, Deputy Director
Office of Statistics and Data Management
Bureau of Data Management and Strategy
Health Care Financing Administration
Oak Meadows Building
6325 Security Boulevard
Baltimore, MD 21207

PURPOSE: The Medicare History Sample was developed to provide a longitudinal person-based data file for statistical research.

DESIGN: The Medicare History File is a 5% sample of all Medicare utilization records based on terminal digits of the Medicare claim number. It is a longitudinal file by person that is updated periodically to include records filed late and to maintain currency by year of medical service.

CONTENT: The file contains demographic data, eligibility data, and Medicare utilization information for a 5% sample of beneficiaries. Records for each stay in hospital or in an extended care facility are added once each year. Summary records for the year are created from physican payment records, home health bills, and outpatient bills and included annually. The utilization data include charge amounts, type of service, dates of service, and diagnoses.

YEARS OF DATA COLLECTION: The file is updated annually. At present the years 1974-1981 are completed.

PUBLICATIONS: Lubitz and Prihoda, "Use and Costs of Medicare Services in the Last Two Years of Life," *Health Care Financing Review*, Volume 5, Issue 3, Spring 1984.

Anderson and Knickman, Adverse Selection Under a Voucher Grouping Medicare Recipients by Level of Expenditure, *Inquiry*, Summer 1984.

Anderson and Knickman, Patterns of Expenditures Among High Utilizers of Medical Care Services: The Experience of Medicare Beneficiaries, 1974-1977, *Medical Care*, February 1984.

McMillan and Cornick, A Study of the "Crossover Population": Aged Persons Entitled to Both Medicare and Medicaid, *Health Care Financing Review*, Volume 4, Issue 4, Summer 1983.

Cornick, Beebe, and Prihoda, Options for Change Under Medicare: Impact of a Catastrophic Illness Expense, *Health Care Financing Review*, Volume 5, Issue 1, Fall 1983.

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SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)
TITLE:	**The Medicare History Sample—1974 and Later**
AVAILABILITY OF UNPUBLISHED DATA:	Data can be made available to contractors and grantees.
CONTACT:	Earl Swartz HCFA (301) 597-5987

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **The Medicare History Sample--1974 and Later**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services (SNF)
x		Home health care
x		Rehabilitation
x		Mental health hospitalization
x		Mental health outpatient services
x		Alcohol and drug abuse centers
x		Physician services/visits
		Dental services/visits
		Prescription drugs
x		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **The Medicare History Sample—1974 and Later**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of Persons in 5% Sample - annually	Nonresponse Rate
Total	1.5 Million	
Under 65		
65-74	.75 Million	
75-84	.40 Million	
85+	.12 Million	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	State		
Smallest unit	County		
Age classes			
Single years	x		
60-64	x		
65+	x		
65-74, 75-84, 85+	x		
Other < 60	x		

SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)
TITLE:	**Medicare Part B (SMI) 5-Percent Sample Bill Summary Record** Project Director: Michael McMullan, Deputy Director Office of Statistics and Data Management Bureau of Data Management and Strategy Health Care Financing Administration Oak Meadows Building 6325 Security Boulevard Baltimore, MD 21207
PURPOSE:	To obtain timely data on the amount, type, place, and cost of health care services used under the Supplementary Medical Insurance (SMI Part B) Program.
DESIGN:	A 5% sample of SMI bills is selected based on the beneficiary's health insurance claim number. It is linked to the Health Insurance Master File for additional beneficiary and provider information.
CONTENT:	Provides information identifying the beneficiary, the physician/supplier, total charges, and reimbursements, as well as data on type and place of service.
YEARS OF DATA COLLECTION:	1976-83--tapes completed, analytic studies ongoing. 1984--ongoing; budgeted and planned.
PUBLICATIONS:	An Analysis of Services Received Under Medicare by Specialty of Physicians, Health Care Financing Review, Volume 3, No. 1, Sept. 1981.
AVAILABILITY OF UNPUBLISHED DATA:	Unpublished data available either as hard copy or magnetic tape for the years 1976 through 1983. Contact Deputy Director, Office of Statistics and Data Management.
CONTACT:	Irving Goldstein HCFA (301) 597-5980

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Part B (SMI) 5-Percent Sample Bill Summary Record**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x	x	Race
		Ethnicity
x	x	Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x	x	Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
x	x	Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Part B (SMI) 5-Percent Sample Bill Summary Record**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of SMI Bills in Sample	Nonresponse Rate
Total	17.7 million	
Under 65	1.6 million	
65-74	8.5 million	
75-84	5.7 million	
85+	2.0 million	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State		
Smallest unit	State		
Age classes			
Single years			
60-64	x		
65+	x		
65-74, 75-84, 85+			
Other			

SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)
TITLE:	**Medicare Reimbursement by State and County** Project Director: James Welsh, Computer Specialist Computer Specialist Office of Statistics and Data Management Bureau of Data Management and Strategy Health Care Financing Administration Oak Meadows Building 6325 Security Boulevard Baltimore, MD 21207
PURPOSE:	To measure utilization of Medicare services.
DESIGN:	All bills reimbursed under the Medicare program are allocated to residence of the beneficiary annually.
CONTENT:	The file shows reimbursement for residents of each state and county enrolled in the Medicare program, as a grand total and separately for the Hospital Insurance Program (HI) and the Supplementary Medical Insurance Program (SMI).
YEARS OF DATA COLLECTION:	Annually since July 1, 1966.
PUBLICATIONS:	Health Care Financing Administration: Medicare Reimbursement by State and County (annual publication, 1967-1980). Annual Medicare Program Statistics, 1981 (No. 03153). Annual Medicare Program Statistics, 1982 (No. 03189).
AVAILABILITY OF UNPUBLISHED DATA:	A tape of published data is available. Contact Office of Statistics and Data Management.
CONTACT:	Charles Fisher HCFA (301) 594-6705

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Reimbursement by State and County**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services (SNF)
x		Home health care
x		Rehabilitation
x		Mental health hospitalization
x		Mental health outpatient services
x		Alcohol and drug abuse centers
x		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicare Reimbursement by State and County**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	1983 Enrollment in Medicare	Nonresponse Rate
Total	30,000,000	
Under 65	3,000,000	
65-74	15,909,000	
75-84	8,488,000	
85+	2,712,000	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	State		
Smallest unit	County		
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+	x		
Other			

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SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)
TITLE:	**MEDPAR Public Use File**
	Project Director: Michael McMullan, Deputy Director Office of Statistics and Data Management Bureau of Data Management and Strategy Health Care Financing Administration Oak Meadows Building 6325 Security Boulevard Baltimore, MD 21207
PURPOSE:	To provide a national sample file containing billing and medical data classified by diagnosis related groups (DRGs) as reported on Medicare short-stay hospital inpatient bills.
DESIGN:	The file is made up of bills for short-stay hospital inpatient services for 20% of the Medicare beneficiaries, selected according to predetermined digits of the health insurance claim number.
CONTENT:	The elements of the billing form (SSA-1453) are contained in the file: age, sex, Medicare status code; length of stay, discharge status; total and Medicare-covered charges; principal diagnosis in ICD-9-CM code and DRG code; and other billing items. All person and hospital identifiers have been removed from the file.
YEARS OF DATA COLLECTION:	Annually since 1980.
PUBLICATIONS:	None.
AVAILABILITY OF UNPUBLISHED DATA:	Tape can be made available through project head.
CONTACT:	Michael McMullan (301) 597-5989

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **MEDPAR Public Use File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
	x	Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
	x	Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **MEDPAR Public Use File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of Discharges in Sample--1982	Nonresponse Rate
Total		
Under 65		
65+	Approx. 2 million	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit		U.S.	
Smallest unit		SMSA	
Age classes			
Single years		x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Analysis of State Medicaid Program Characteristics**

Project Director:
Kim Wivell, Statistician
Medicaid Statistics Branch
Office of Financial and Actuarial Analysis
Health Care Financing Administration
Oak Meadows Building
6325 Security Blvd.
Baltimore, MD 21207

PURPOSE: To provide a single comprehensive source of information regarding the policy and operating characteristics of state Medicaid programs.

DESIGN: All states are requested to update items such as eligibility and provider reimbursement policies, in addition to providing aggregate data on items such as certified bed supply data and expenditures spent on state-only programs. Much of the information requested is available from various sources within the state offices.

CONTENT: The data base updated annually contains information on: state eligibility policy for mandatory, optional, and medically needy groups; service coverage and limitations; provider reimbursement policies; administration and finance characteristics; demographic, economic, and medical sector characteristics; and state-only programs.

YEARS OF DATA COLLECTION: Annually since 1982; updated in 1983 and 1984. There will be no 1985 report, but a 1986 study is anticipated pending Office of Management and Budget approval of the data collection.

PUBLICATIONS: Analysis of State Medicaid Program Characteristics, 1982, 1983. Prepared under contract to HCFA by La Jolla Management Corporation, December 1983. The 1984 report was expected in October 1985.

AVAILABILITY OF UNPUBLISHED DATA: Data contained in the report available on machine-readable computer tapes. A copy of the report can be obtained for 1982, 1983, and 1984 from Office of the Actuary, Division of Medicaid Cost Estimates, Health Care Financing Administration.

CONTACT: Kim Wivell
(301) 594-8051

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Analysis of State Medicaid Program Characteristics**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
x	x	SOCIAL SERVICES
		HEALTH RESOURCES (aggregate)
x	x	General hospitals
x	x	Private psychiatric hospitals
x	x	Public mental health hospitals
x	x	Nursing homes
x	x	Other institutional resources
x	x	Community-based resources
x	x	Health professions
x	x	Other professional resources
		HEALTH EXPENSES (aggregate)
x	x	Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
x	x	Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Analysis of State Medicaid Program Characteristics**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit	State	State	State
Age classes			
Single years			
60-64			
65+	x	x	x
65-74, 75-84, 85+			
Other			

SPONSOR: Health Care Financing Administration (HCFA) Department of Health and Human Services (DHHS)

TITLE: **Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, Medicaid Program**

Project Director:
Christopher E. Howe, Program Analyst
Medicaid Statistics Branch
Office of Financial and Actuarial Analysis
Health Care Financing Administration
Oak Meadows Building
6325 Security Blvd.
Baltimore, MD 21207

PURPOSE: To monitor past and projected future trends in the Medicaid program as well as serving as the basis of analysis and cost saving estimates for the Department of Health and Human Services' cost-sharing legislative initiatives to Congress.

DESIGN: Reporting on Form HCFA-2082, Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services is required annually of all state agencies administering or supervising the administration of an approved plan for a federally aided Title XIX program. Reports cover the federal fiscal year. Data reported on the basis of individuals receiving medical care, not cases or families.

CONTENT: Various parts of Form HCFA-2082 provide for reporting the following information on an annual basis:

(1) Request of medical assistance by maintenance assistance status and basis of eligibility and type of medical care.
(2) Recipients and amounts of medical vendor payments by age, sex, and race, and by type of medical care.
(3) Discharges of recipients from general hospitals.
(4) Recipients of inpatient hospital services, skilled nursing facilities, intermediate care facilities, and intermediate care facilities/mentally retarded.
(5) Physician visits, rural health visits, home health visits, and number of prescriptions.
(6) Eligibles' and recipients' expenditures for service categories and by maintenance assistance status (cash, noncash, and medically needy) and basis of eligibility (AFDC, aged, blind, or disabled or other Title XIX).
(7) Institutionalized recipients' expenditures.
(8) Capitation information.

YEARS OF DATA COLLECTION: Form HCFA-2082 has been used continuously since FY 1972. It is approved through at least February 1987 in its current format. Information is available as received. Form is due January 15 following the fiscal year for which statistics were collected.

SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)
TITLE:	**Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, Medicaid Program**
PUBLICATIONS:	Tables 6,7,8, and 9 which appear quarterly in the HCFA Review. The Medicare-Medicaid Data Book: Program Characteristics, 1981-1983.
AVAILABILITY OF UNPUBLISHED DATA:	Data available on machine-readable computer tapes and also available in unpublished state Medicaid tables. To obtain copies, contact: Office of the Actuary, Division of Medicaid Cost Estimates; J-1, EQ05-6325 Security Boulevard, Baltimore, MD 21207.
CONTACT:	Tony Parker HCFA (301) 597-1417

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, Medicaid Program**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
x	x	SOCIAL SERVICES
		HEALTH RESOURCES (Aggregate)
x	x	General hospitals
x	x	Private psychiatric hospitals
x	x	Public mental health hospitals
x	x	Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x	x	Costs of care
		Out-of-pocket costs
		Medicare
x	x	Medicaid
x	x	State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
		Rehabilitation
x	x	Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
x	x	Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, Medicaid Program**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable Data are not sampled	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Not applicable		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Service (DHHS)
TITLE:	**Linked Medicare Use--NCHS Mortality Statistics File**
	Project Director: James Lubitz Chief, Analytical Studies Branch Office of Research and Demonstrations Health Care Financing Administration Room 2D15, Oak Meadows Building 6340 Security Boulevard Baltimore, MD 21207
PURPOSE:	To study the relation of use of Medicare-covered services to cause of death.
DESIGN:	The Medicare utilization and enrollment information in the Continuous Medicare History Sample was linked to the mortality statistics file of the National Center for Health Statistics for a 5% random sample of Medicare enrollees who died in 1979. Of the 70,000 decedents, records were linked for 94%.
CONTENT:	Use and cost of Medicare-covered benefits (hospital, physician, home health, skilled nursing facility, hospital outpatient) linked to death certificate data including cause of death. Detail contained in descriptions of Continuous Medicare History File and Mortality Statistics file.
YEARS OF DATA COLLECTION:	1979.
PUBLICATIONS:	None yet.
AVAILABILITY OF UNPUBLISHED DATA:	Not available.
CONTACT:	James Lubitz (301) 597-1460

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Linked Medicare Use—NCHS Mortality Statistics File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
x (limited)		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
x (limited)		Out-of-pocket costs
x		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION (for Medicare covered services)
x		General hospital services
x		Nursing home services
x		Home health care
		Rehabilitation
x		Mental health hospitalization
x		Mental health outpatient services
		Alcohol and drug abuse centers
x		Physician services/visits
		Dental services/visits
		Prescription drugs
x		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Linked Medicare Use—NCHS Mortality Statistics File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	63,720	
Under 65		
65-74	21,821	
75-84	24,889	
85+	17,010	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	U.S.		
Smallest unit	County		
Age classes			
Single years	x		
60-64	x		
65+	x		
65-74, 75-84, 85+	x		
Other			

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SPONSOR:	Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)
TITLE:	**Medicaid Tape-To-Tape Project**
	Project Director: Dave Baugh/Penelope Pine Project Officers Office of Research, Division of Program Studies Office of Research and Demonstrations Health Care Financing Administration Oak Meadows Building 6340 Security Boulevard Baltimore, MD 21207
PURPOSE:	This project was initiated to expand the agency's ability to collect data to analyze the Medicaid program.
DESIGN:	The main data base consists of 100% data from five participating states (California, Georgia, Michigan, New York, and Tennessee) in uniform codes and formats. States send their Medicaid Management Information System (MMIS) tapes, which are edited into a comparable format for analysis.
CONTENT:	Uniform files are produced for each participating state and year. Separate files are maintained for enrollment, claims, and provider data. Claims, provider, and reimbursements can be linked to the Medicaid enrollee who received the service, and to the provider who furnished it.
YEARS OF DATA COLLECTION:	1980-1982 data from the five participating states have been collected and uniform files completed. 1983-1984 data from participating states are being collected at this time.
PUBLICATIONS:	Fagan-Berluochi, Aileen, Recipients of Covered Services Among Medicaid Enrollees: Michigan and New York, 1981, Health Care Financing Notes, No. 3, December 1984. Pine, P.L., D.K. Baugh, et al., The Medicaid Tape-to-Tape Project: Empirical Use of a Uniform Data Base. Proceedings: The Ninth Annual Symposium on Computer Applications in Medical Care. Other publications are being prepared.
AVAILABILITY OF UNPUBLISHED DATA:	Limited information may be available from unpublished tabulations.
CONTACT:	Penelope Pine (301) 597-1454

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicaid Tape-to-Tape Project**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x		General hospitals
x		Private psychiatric hospitals
x		Public mental health hospitals
x		Nursing homes
x		Other institutional resources
x		Community-based resources
x		Health professions
x		Other professional resources
		HEALTH EXPENSES
x		Costs of care
		Out-of-pocket costs
x		Medicare
x		Medicaid
x		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
x		Home health care
x		Rehabilitation
x		Mental health hospitalization
x		Mental health outpatient services
		Alcohol and drug abuse centers
x		Physician services/visits
x		Dental services/visits
x		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medicaid Tape-to-Tape Project**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Medicaid Population	Nonresponse Rate
Total *	6,869,711	
Under 65	5,808,159	
65-74	448,841	
75-84	382,801	
85+	210,262	

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* For 3 States: California, Michigan, and New York.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	State		State
Smallest unit	Zip code		
Age classes			
Single years	x		
60-64	x		x
65+	x		x
65-74, 75-84, 85+	x		x
Other			

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medigap**

CONTRACTOR: SRI International, Menlo Park, California

Project Director:
Judith Sangl, Research Analyst
Office of Research/LTSSB
Office of Research and Demonstrations
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

PURPOSE: The survey was conducted to analyze the effectiveness of varying state insurance regulations on limiting agent and marketing abuse, promoting policies that provide reasonable economic benefits; improving price competition; improving informed choice; and reducing duplicative coverage.

DESIGN: Stratified random sample of 1,657 Medicare beneficiaries age 65 and over in six states (California, Florida, Mississippi, New Jersey, Washington, and Wisconsin) who owned a Medicare supplemental policy, had both Part A and Part B coverage, and were not jointly covered by Medicaid. In addition, there was a sample of 799 similar Medicare beneficiaries who did not own supplemental insurance.

CONTENT: Information was collected on:

(1) Use of Medicare services.
(2) Knowledge of the Medicare program.
(3) Knowledge of private health insurance policies owned.
(4) Experience with policies, companies, and agents.
(5) Experience with information available to purchasers of supplemental health insurance policies.
(6) Socioeconomic characteristics.

YEARS OF DATA COLLECTION: 1982 (one time only).

PUBLICATIONS: McCall, N., Rice, T., and Hall, A., Medigap--Study of Comparative Effectiveness of Various State Regulations, Final Report, Stanford Research Institute, September 1983.

AVAILABILITY OF UNPUBLISHED DATA: Data will be available in future to contractors and grantees.

CONTACT:
Judith Sangl
(301) 597-5717

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medigap**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
x		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
		Sources of income
x		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x		Medicare
		Medicaid
		State expenditures
x		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Insurance policy information

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **Medigap**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	4,555	14%
Under 65	0	
65+	4,555	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State		State
Smallest unit	State		State
Age classes			
Single years	x		
60-64			
65+	x		x
65-74, 75-84, 85+	x		
Other (65-69; 70-74; 75+)	x		x

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **1984 Long-Term Care Survey**

Project Director:
Candace Macken, Statistician
Office of Research
Office of Research and Demonstrations
Health Care Financing Administration
6340 Security Boulevard
Baltimore, MD 21207

PURPOSE: The data collected in the 1984 Long-Term Care Survey follows up those persons included in the National Survey of Long-term Care/National Survey of Caregivers, 1982 (see p. 70). The data provide both a cross-sectional look at functionally impaired persons ages 65 and over no matter where they reside and a longitudinal look at the transitions from independent living in the community to dependence in the community or in institutions, to death.

DESIGN: The sample includes all those persons interviewed in the 1982 Long-Term Care Survey who had problems performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs), a subsample of persons who had no functional limitations in 1982 but were found to have limitations in 1984, all persons not included in 1982 because they were institutionalized, and a subsample of persons who have aged into the sample, i.e., persons who were 63 and 64 in 1982 and were 65 and 66 in 1984. The first 3 groups compose the longitudinal component, and all 4 compose the cross-sectional component.

CONTENT: Information was gathered for persons living in the community on the number and degree of ADL/IADL limitations, cognitive functioning, paid and unpaid caregivers services, use of medical services, insurance coverage, income, and assets. For persons in institutions, data were gathered on the number and degree of ADL limitations, cognitive functioning, source of payment for nursing home stay, and size of institution and bed certification under Medicare and Medicaid. For deceased sample persons, data were gathered on place of death, place of residence prior to death, source of payment at place of death, formal caregivers, and income.

YEARS OF DATA COLLECTION: 1984.

PUBLICATIONS: Not yet available.

AVAILABILITY OF UNPUBLISHED DATA: Data are going through preliminary data processing at this time.

CONTACT:
Candace Macken
(301) 597-1435

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SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: **1984 Long-Term Care Survey**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
x	x	SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x	x	Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x	x	Morbidity
x	x	Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
		Rehabilitation
x	x	Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
x	x	Prescription drugs
x	x	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS)

TITLE: 1984 Long-Term Care Survey

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	24,097	5.2%
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	X	X	
Social Security no.			
Veteran status	X	X	
Geographic data	National	National	
Largest unit	Census region	Census region	Smallest unit
Zip code	County		
Age classes			
Single years	X	X	
60-64			
65+			
65-74, 75-84, 85+			
Other			65-69, 70-74, 75-79,80-84, 85+

SPONSOR: Internal Revenue Service (IRS)

TITLE: **Estate/Personal Wealth File**

Project Director:
Marvin Schwartz, Statistician
Foreign/Special Projects Section
Statistics of Income Division
Internal Revenue Service
1201 E Street, NW, Room 500
Washington, DC 20224

PURPOSE: Collection of data from federal estate tax returns for the purpose of tax administration and for use in the production of personal wealth estimates.

DESIGN: Sample of estate tax returns filed each year. Sample size varies from year to year. Sample based on year of death, age at death, and size of gross estate.

CONTENT: Identifying information, demographic information, asset amounts, liabilities, deductions, net worth, estate tax computation.

Periodically, information on beneficiaries and amounts of bequests are collected.

YEARS OF DATA COLLECTION: Micro data files have been completed for estate tax returns filed in 1963, 1966, 1970, 1973, 1977, and for 1982 through 1984. Currently, the study is conducted annually. Data on personal wealth were published most recently in the winter 1984-1985 Bulletin; more complete data will be released in winter 1986-1987.

PUBLICATIONS: Bentz, Mary F., "Using the National Death Index to Establish a Relationship between Wealth and Mortality," Internal Revenue Service, September 1984 (unpublished working paper).

Bentz, Mary F., and Schwartz, Marvin, "Continuing the IRS Estimates of Personal Wealth in the United States," *1984 American Statistical Association Proceedings, Survey Research Methods Section*.

Guyeska, Linda, "The Feasibility of the Research of Inter Vivos Transfers of Wealth: The Gift Tax Pilot Study," Internal Revenue Service, October, 1984 (unpublished working paper).

Schwartz, Marvin, "Trends in Personal Wealth," *Internal Revenue Service, Statistics of Income Bulletin*, Internal Revenue Service, Volume 3, Number 1, Summer 1983.

SPONSOR: Internal Revenue Service (IRS)

TITLE: **Estate/Personal Wealth File**

Schwartz, Marvin, "An Evaluation of the Condition of Archived Federal Estate Tax Returns With an Eye Toward Their Potential for Use in Wealth Related Studies," Internal Revenue Service, May 1984 (unpublished working paper).

For further information, see also Smith, James D., "Socio-economic Structure and Dynamics of American Households in the Twentieth Century." Survey Research Center, University of Michigan, August 1984 (unpublished).

Schwartz, Marvin, "Estimates of Personal Wealth, 1982," Statistics of Income Bulletin, Winter 1984-1985.

Bentz, Mary F., "Estate Tax Returns, 1983," Statistics of Income Bulletin, Fall 1984.

AVAILABILITY OF UNPUBLISHED DATA: Public use data tapes can be purchased for the years 1973, 1977, 1982, 1983, and 1984. Contact Marvin Schwartz.

CONTACT:
Marvin Schwartz
Internal Revenue Service
1111 Constitution Avenue
Washington, DC 20224
Attn: D:R:S:F, Room 500
(202) 376-0199

SPONSOR: Internal Revenue Service (IRS)

TITLE: **Estate/Personal Wealth File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
x		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Asset information
x		Estate tax computation

SPONSOR: Internal Revenue Service (IRS)

TITLE: **Estate/Personal Wealth File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not available	
Under 65		
65-74		
75-84		
85+		

Varies from year to year and based on size of estate.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	Nation		Nation
Smallest unit	State		State
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other: Under 45, 45-59, 60-69, 70-79, 80-89, 90+			x

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SPONSOR: Internal Revenue Service (IRS)

TITLE: **Statistics of Income: Individual Income Tax Returns**

Project Director: Chief
Individual Returns Analysis Section
Statistics of Income Division, D:R:S:I
Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

PURPOSE: The production of individual income tax statistics was authorized by the Revenue Act of 1916. Statistics of income data are used by a variety of agencies for tax system and economic analyses.

DESIGN: Statistics of income data are estimated from a stratified probability sample of income tax returns and supporting schedules filed with the Internal Revenue Service. The sample is based on such criteria as: principal business activity; presence or absence of a schedule; state from which filed; size of adjusted gross income (or deficit) or largest of specific income (or loss) items; total assets or size of business and farm receipts. The sample size alternates from 80,000 to 120,000 returns each year, selected from a population of approximately 96 million returns. Special searches are conducted for returns selected so that any bias from nonresponse is minimal. A large proportion of the sample is longitudinal and research on the longitudinal design of the sample is being conducted. The individual income tax returns sample does not make use of data linked to other files, however, certain other statistics of income studies do use linked data files.

CONTENT: Data relative to taxpayers' income, exemptions, deductions, credits, and tax are collected. Due to changes in tax laws, items collected vary from tax year to tax year.

YEARS OF DATA COLLECTION: Data are collected for each tax year. Individual income tax data are currently available for tax years 1913 through 1983. These data will continue to be collected, processed, and published in future years.

PUBLICATIONS: Annual: Statistics of Income--Individual Income Tax Returns, Internal Revenue Service.

Quarterly: Statistics of Income Bulletin, Internal Revenue Service.

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SPONSOR: Internal Revenue Service (IRS)

TITLE: **Statistics of Income, Individual Income Tax Returns**

AVAILABILITY OF UNPUBLISHED DATA: Unpublished tabulations and/or public use data tapes are available on a reimbursable basis. Requests for data should be directed to:

> Director, Internal Revenue Service, Statistics of Income
> Division, D:R:S, 1111 Constitution Avenue, NW,
> Washington, DC 20224. Telephone (202) 376-0216

CONTACT:

David Paris
IRS
(202) 376-0001

SPONSOR: Internal Revenue Service (IRS)

TITLE: **Statistics of Income, Individual Income Tax Returns**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
x	x	Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Internal Revenue Service (IRS)

TITLE: **Statistics of Income, Individual Income Tax Returns**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Approx. 88,000 Returns *	
Under 65	Approx. 75,000 Returns *	
65-74		
75-84		
85+		

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* Size of sample for tax year 1982. Sample sizes alternate by tax year.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	State	State	State
Age classes			
Single years			
60-64			
65+	x	x	x
65-74, 75-84, 85+			
Other			

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SPONSOR: National Cancer Institute (NCI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Surveillance, Epidemiology, and End Results (SEER) Program**

Project Director: John L. Young, Jr., Chief
Demographic Analysis Section
National Cancer Institute
Blair Building
Bethesda, MD 20205

PURPOSE: To monitor the incidence of and survival from cancer in the United States for purposes of carrying out the mandates in the National Cancer Act.

DESIGN: Data are collected on a population base in 10 geographic areas of the United States and in Puerto Rico. The sample represents 12% of the total population of the United States as a whole, but, within a given geographic area, data are collected on 100% of the population.

CONTENT: The data set contains demographic information (race, sex, age, birthplace, marital status, census tract) of the patient, medical information (histologic type, anatomic site, laterality, diagnostic procedures, diagnostic confirmation, sequence) in regard to the tumor, extent of disease and treatment of the lesion, and outcome.

Code Manual: Cancer Surveillance, Epidemiology, and End Results Reporting--SEER Program. NIH Pub. No. 79-1999, revised October 12, 1983, 5th ed.

YEARS OF DATA COLLECTION: Data collection began in 1973 for 8 registries, 1974 for 1 registry, 1975 for 1 registry, and 1979 for the latest registry added to the program.

PUBLICATIONS: Bibliography available from project head. Reprints are available for many reports, including the following selection of statistical studies:

Cutler, S.J., and Young, J.L., Jr. Demographic Patterns of Cancer Incidence in the United States. Persons at High Risk of Cancer: An Approach to Cancer Etiology and Control. New York: Academic Press, 1975.

Devesa, S.S., and Silverman, D.T. Trends in incidence and mortality in the United States. J Environ Pathol Toxicol 3:127-155, 1980.

Young, J.L., Jr., and Pollack, E.S. The incidence of cancer in the United States. Pp. 138-165 in D. Schottenfeld and J.F. Fraumeni, Jr., eds., Cancer Epidemiol and Preven, Philadelphia: Saunders, 1982.

SPONSOR:	National Cancer Institute (NCI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
TITLE:	**Surveillance, Epidemiology, and End Results (SEER) Program**
AVAILABILITY OF UNPUBLISHED DATA:	Public use tapes corresponding to published data are available. These tapes contain more detailed data than are available in the publications themselves. For data items not previously analyzed, tabulations are available from NCI.
CONTACT:	John L. Young, Jr. (301) 427-8829

SPONSOR: National Cancer Institute (NCI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Surveillance, Epidemiology, and End Results (SEER) Program**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
x	x	Natality
x	x	Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	Cancer diagnosis

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SPONSOR: National Cancer Institute (NCI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Surveillance, Epidemiology, and End Results (SEER) Program**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	(1973-1982) Number in Sample	Nonresponse Rate
Total	690,150	
Under 65	325,911	
65-74	189,413	
75-84	131,993	
85+	42,833	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Year only	Year only	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	County	County	State/metro area
Smallest unit	Census tract	County	State/metro area
Age classes			
Single years	x	x	
60-64	x		x
65+	x		
65-74, 75-84, 85+	x		x
Other			

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SPONSOR:	National Center for Health Services Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services (DHHS)
TITLE:	**Hospital Cost and Utilization Project: National Sample of Hospitals**
	Project Director: Rosanna M. Coffey, Director Hospital Studies Program Division of Intramural Research National Center for Health Services Research 350 Park Building 5600 Fishers Lane Rockville, MD 20857
PURPOSE:	To facilitate analysis of differences among short-term hospitals in their use of services, costs of providing care, and other aspects of behavior.
DESIGN:	A sample of 370 short-term acute care nonfederal hospitals that had computerized discharge abstract data for years 1970 through 1977. The discharge abstract data can be linked to several other files, such as American Hospital Annual Survey of Hospitals, DHHS Area Resource File, and a physician characteristics file for 160 of the 370 sample hospitals.
CONTENT:	The file includes nearly all information contained on computerized patient discharge abstract records. Variables include patient's age, race, sex, principal insurance, up to seven diagnoses codes, up to seven procedure codes, dates of admission and discharge, days in special care units, and discharge status.
YEARS OF DATA COLLECTION:	1970-1977: already collected. 1980-1984: in process of collection; available mid-1986. 1985-1987: planned.
PUBLICATIONS:	See "Annotated Bibliography of the Hospital Studies Program," Publication and Information Branch, Room 1-46, Park Building, 5600 Fishers Lane, Rockville, MD 20857.
AVAILABILITY OF UNPUBLISHED DATA:	Contact project head for information on access to unpublished aggregate statistics from this study. No public-use tape will be prepared.
CONTACT:	Rosanna M. Coffey (301) 443-5706

SPONSOR: National Center for Health Services Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services (DHHS)

TITLE: **Hospital Cost and Utilization Project: National Sample of Hospitals**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
		Out-of-pocket costs
x		Medicare
x		Medicaid
		State expenditures
x		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: National Center for Health Sevices Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services (DHHS)

TITLE: **Hospital Cost and Utilization Project: National Sample of Hospitals**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	No. of Discharges (1970-1977)	Nonresponse Rate
Total	20,000,000	(Small at the
Under 65	19,200,000	patient level;
65-74	400,000	but about 55%
75-84	300,000	at hospital
85+	100,000	level)

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit	Nation		
Smallest unit	Zip code		
Age classes			
Single years	x		
60-64	x		
65+	x		
65-74, 75-84, 85+	x		
Other	x		

SPONSORS: National Center for Health Services Research and Health Care Technology Assessment (NCHSR) and National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Medical Care Expenditures Survey (NMCES), 1977-78**

CONTRACTORS: Research Triangle Institute, NC; National Opinion Research Center of the University of Chicago, and Abt Associates, Inc. of Cambridge, MA

Project Director: Daniel C. Walden, Senior Research Manager
Division of Intramural Research
National Center for Health Services Research
350 Park Building
5600 Fishers Lane
Rockville, MD 20857

PURPOSE: The National Medical Care Expenditures Survey was designed to provide a comprehensive statistical picture of how health services are used and paid for in the United States.

DESIGN: NMCES is a one-time panel sample that interviewed about 40,000 persons in 14,000 randomly selected households in the civilian, noninstitutionalized population. The sample design is a stratified, multistage, area probability sample that allows for the determination of approximately unbiased estimates of health parameters at the national level. Respondents were interviewed six times over an 18-month period during 1977 and 1978. The survey was complemented by additional surveys of physicians and health care facilities providing care to household members during 1977 and of employers and insurance companies responsible for their insurance coverage. The principal NMCES response rate was 82%, defined as the proportion of eligible first-round reporting units that responded to all rounds of interviewing.

CONTENT: Data collected includes but is not limited to: expenditures and sources of payment for all major forms of medical care; sociodemographic and economic characteristics of respondents; insurance coverage of respondents; information from medical providers about respondents; and access to medical care.

YEARS OF DATA COLLECTION: NMCES consists of six rounds of data collection covering an 18-month period between 1977 and part of 1978. A 1987 National Medical Expenditure Survey (NMES) is planned jointly with NCHSR and the Health Care Financing Administration. The household sample is expected to have about 14,000 households including oversamples of blacks, Hispanics, low-income people and people with functional limitations. The Institutional Population Component sample

SPONSORS: National Center for Health Services Research and Health Care Technology Assessment (NCHSR) and National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Medical Care Expenditure Survey (NMCES), 1977-78**

will include about 13,000 clients of nursing and personal care homes, psychiatric hospitals, and facilities for the mentally retarded.

PUBLICATIONS: See "Annotated Bibliography of the National Health Care Expenditures Study," National Center for Health Services Research and Health Care Technology Assessment, 1985.

AVAILABILITY OF UNPUBLISHED DATA: Public use tapes are now available for person-based information and on events of medical care from the National Technical Information Service. Additional public-use files on insurance coverage, employer characteristics, and episodes of illness will be available from NTIS in the future.

The present person public-use file contains one record per person on population characteristics, health status, access to care, health insurance coverage, and on use, expenditures, and sources of payment for medical and related services. The data file also has the capacity to link sample members to specific households so that family analyses can be undertaken. The survey reference period is 1 January to 31 December 1977.

Two versions of the file are available from the National Technical Information Service--a Statistical Analysis System (SAS) file and an Extended Binary Coded Decimal Interchange Code (EBCDIC) file. The ordering number for the SAS version is PB 83-198077 and it is PB 83-199539 for the EBCDIC version.

The documentation for this file, which is included in the purchase price, contains a description of NMCES; information on sample design, construction of population weights, and methods of variance estimation; information on imputation of missing data and related procedures; description of file structure and content; and technical notes.

Another public use data set from NMCES, available at NTIS, contains one record per event of use of hospital, physician, nonphysician, and dental services as well as one record per event of use of prescribed medicines, eye-glasses and contact lenses, and medical equipment and supplies. Each file contains information on variables related to use, such

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SPONSORS: National Center for Health Services Research and Health Care Technology Assessment (NCHSR) and National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Medical Care Expenditure Survey (NMCES), 1977-78**

as charges, sources of payment, length of stay, sites of care, and conditions. The data files have the capacity to link events of care to members of the NMCES sample in the person record data sets. The titles and ordering numbers are as follows:

> National Medical Care Expenditure Survey Household Data: Hospital, Physician, Nonphysician and Dental Records SAS Files, PB 85-246619.
>
> National Medical Care Expenditure Survey Household Data: Hospital, Physician, Nonphysician and Dental Records EBCDIC Files, PB 85-246635.
>
> National Medical Care Expenditure Survey Household Data: Prescribed Medicines, Eyeglasses and Contact Lenses and Medical Equipment and Supplies Records SAS Files, PB 85-246627.
>
> National Medical Care Expenditure Survey Household Data: Prescribed Medicines, Eyeglasses and Contact Lenses and Medical Equipment and Supplies Records EBCDIC Files, PB 85-246643.

The files can be purchased from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.

CONTACT: Daniel C. Walden
(301) 443-4836

SPONSORS: National Center for Health Services Research and Health Care Technology Assessment (NCHSR) and National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Medical Care Expenditures Survey (NMCES), 1977-78**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
x	x	Natality
x	x	Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x	x	Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
		Nursing home services
x	x	Home health care
		Rehabilitation
x	x	Mental health hospitalization
x	x	Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
x	x	Prescription drugs
x	x	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSORS: National Center for Health Services Research and Health Care Technology Assessment (NCHSR), and National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: National Medical Care Expenditures Survey (NMCES), 1977-78

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	40,320	18%
Under 65	35,760	
65-74	2,862	
75-84	1,362	
85+	372	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	Census division	Census division	Census division
Age classes			
Single years	x	x	x
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: National Center for Health Services Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services (DHHS)

TITLE: **Outcomes of Nursing Home Admissions**

Project Director: Mary Ann Lewis, Adjunct Associate
Professor, Medicine and Nursing
General Internal Medicine and
Health Services Research Division
Department of Medicine
UCLA Health Sciences Center
Los Angeles, CA 90024

PURPOSE: To develop models to predict the outcomes of patients admitted to skilled nursing care facilities, develop baseline data to assess the effects of the hospital- based diagnosis related group (DRG) prospective payment system on nursing home patients.

DESIGN: Of the 46 nursing homes in the urban areas of the Standard Metropolitan Statistical Area of San Bernardino, Riverside, and Ontario, California 45 participated in the study. This longitudinal study compares the discharge outcomes of a 1982-83 pre-DRG (n = 2,026) 1984 post-DRG (n = 950) with a 1980 pre-DRG (n = 563) cohort.

An earlier study (1980) served as a pilot for the present research. In the 1980 study, 24 nursing homes were randomly selected from 51 facilities in the urban areas of San Bernardino, Riverside, Ontario, Standard Metropolitan Statistical Area. A random sample of 563 (1980 pre-DRG) patients was selected from all patients discharged from the 24 facilities. A total of 529 patients were tracked for 2 years to assess utilization of hospitals and nursing homes.

CONTENT: The characteristics of patients at admission to the nursing home were collected.

Age, sex, marital status, legal competence, source of payment, (i.e., self-pay, Medicare, Medicaid), prior living residence, ability to ambulate, perform activities of daily living, mental status, behavioral problems, medical diagnosis, visitors during first month, medications, length of stay, discharge outcome including disposition following hospitalization, utilization of hospitals and nursing homes up to 2 years, and status at 2 years following initial nursing home discharge.

YEARS OF DATA COLLECTION: The pilot study was based on discharges in 1980; the final study on discharges in 1982-83 and 1984.

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SPONSOR: National Center for Health Services Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services, (DHHS)

TITLE: **Outcomes of Nursing Home Admissions**

PUBLICATIONS: The 1980 study has been reported in:

Lewis, M.S., Kane, R., Cretin, S., and Clark, V., "The Immediate and Subsequent Outcomes of Nursing Home Care," American Journal of Public Health, Vol. 75, No. 7, 1985.

Lewis, M.S., Cretin, S., and Kane, R., "The Natural History of Nursing Home Patients."

The 1984 study is not yet completed.

AVAILABILITY OF UNPUBLISHED DATA: For the 1980 study, see: Lewis, Mary Ann, "The Immediate and Subsequent Outcomes of Nursing Home Care." University of California, Los Angeles, 1984. University Microfilms International, 300 North Zeeb Road, Ann Arbor, MI 48106.

CONTACT: Mary Ann Lewis
(213) 825-8476

SPONSOR: National Center for Health Services Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services (DHHS)

TITLE: **Outcomes of Nursing Home Admissions**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
x		Nursing homes
x		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
		Out-of-pocket costs
x		Medicare
x		Medicaid
		State expenditures
x		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
x		Behavior problems
x		Depression
		Alcohol use
		Drug abuse
		CHANGES IN:
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
x		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Center for Health Services Research and Health Care Technology Assessment (NCHSR), Department of Health and Human Services (DHHS)

TITLE: **Outcomes of Nursing Home Admissions**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
65+		
1980	563	
1982-3	2,026	
1984	950	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veterans status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+	x		
65-74, 75-84, 85+	x		
Other			

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Hispanic Health and Nutrition Examination Survey (HHANES)**

Project Director: Robert S. Murphy, Director
Division of Health Examination Statistics
Center Building, Room 2-58
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: To produce estimates of health and nutritional status for the three major Hispanic subgroups comparable to estimates available for the general population from the National Health and Nutrition Examination Surveys. These estimates would include the prevalence of certain diseases and the distribution of a broad variety of health-related measurements.

DESIGN: The HHANES was a cross-sectional study covering three universes: Mexican-Americans in five southwestern states; Cuban-Americans in Dade County, Florida; and Puerto Ricans in and around New York City. Overall, of approximately 16,000 sample persons, approximately 12,000 persons (75%) were interviewed and examined. Sample persons were between the ages of 6 months and 74 years inclusive and were noninstitutionalized civilians.

CONTENT: Laboratory analyses, diagnostic tests, interviews, body measurements, and physical and dental examinations were used to collect measures of health and nutritional status. Target conditions of this survey included diabetes, hypertension, heart disease, gallstones, dental disease, otitis media and hearing problems, vision, kidney disease, liver disease, alcohol consumption, drug abuse, depression, iron status, overweight and obesity, dietary adequacy, and body burden of pesticide residues.

YEARS OF DATA COLLECTION: July 1982 through December 1984.

PUBLICATIONS: National Center for Health Statistics, "Plan and Operation of the Hispanic Health and Nutrition Examination Survey, 1982-1984." Prepared by K. Maurer. In Vital and Health Statistics, Series 1-No. 19, DHHS Pub. NO. (PHS) 85-1321, September 1985.

AVAILABILITY OF UNPUBLISHED DATA: Public-use data tapes are scheduled to become available beginning in December 1985.

CONTACT: Patricia A. Vaive
NCHS
(301) 436-7080

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Hispanic Health and Nutrition Examination Survey (HHANES)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
x		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x		Physician services/visits
x		Dental services/visits
x		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Examination findings
x		Nutritional status

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Hispanic Health and Nutrition Examination Survey (HHANES)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample*	Nonresponse Rate
Total	15,931	27%
Under 65	15,320	26%
65-74	611	39%
75-84		
85+		

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* Figures are preliminary.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	X		
Social Security no.	X		
Veteran status	X		
Geographic data			
Largest unit	*		
Smallest unit	**		
Age classes			
Single years	X		
60-64	X		
65+			
65-74, 75-84, 85+	65-74		
Other	6 mos.-74 yrs		

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* Mexican-American population in 5 southwestern states, Cuban-Americans in Dade County, Florida, and Puerto Ricans in and around New York City.

** The three groups above, separately and at the county or borough level.

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Life Tables, Vital Statistics of the United States**

Project Director:
Harry Rosenberg
Chief, Mortality Statistics Branch, and
Robert Armstrong
Actuarial Advisor
Division of Vital Statistics
National Center for Health Statistics
3700 East-West Highway
Hyattsvi'le, MD 20782

PURPOSE: To summarize death rates in order to obtain standardized measures of comparative longevity.

DESIGN: For annual complete tables, numerators are deaths by single years of age for a calendar year; for decennial tables, numerators are deaths by single years of age for the 3-year period around a census year. For abridged tables, life tables contain values by age groups. Provisional life tables are based on a 10% sample compared with final tables, which are based on a complete count of deaths. Denominators for decennial tables are based on decennial census data, while denominators for annual tables are based on midyear postcensal population estimates from the Bureau of the Census. Life tables are also computed by cause of death.

CONTENT: See Publications.

YEARS OF DATA COLLECTION:
Complete life tables, United States, decennially, since 1900; and annually since 1960.
Abridged life tables, United States, annually, since 1945.
Provisional life tables, United States, annually since 1958.
Decennial life tables, states, since 1940 (every 10 years).

PUBLICATIONS: Complete tables: *Vital Statistics of the United States, Mortality*, Vol. II, *Part A*. National Center for Health Statistics.

U.S. Decennial Life Tables. National Center for Health Statistics. (Publication includes tables for individual states and for selected causes of death).

Provisional tables: *Monthly Vital Statistics Report*, "Annual Summary of Births, Deaths, Marriages, and Divorces, United States." National Center for Health Statistics.

AVAILABILITY OF UNPUBLISHED DATA: Latest tables available on request.

CONTACT:
Robert J. Armstrong (decennial life tables)
(301) 436-8951

Harry M. Rosenberg (annual data-provisional and final life tables)
(301) 436-8884

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Life Tables, Vital Statistics of the United States**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
X		Race
		Ethnicity
X		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
X		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
*		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* Decennial life tables by cause of death

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Life Tables, Vital Statistics of the United States**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit			U.S.
Smallest unit			State
Age classes			
Single years			x (decennial)
60-64			x (annual)
65+			x (annual)
65-74, 75-84, 85+			x (annual)
Other			

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Longitudinal Study of Aging (LSOA)**

Project Director: Mary Grace Kovar
Interview and Examination Statistics
Program
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: Study changes in functional status. Develop transitional probability models. Study relationship between social and health factors and death.

DESIGN: The Longitudinal Study on Aging is a prospective study based on respondents to the Supplement on Aging, a special set of questions added to the National Health Interview Survey in 1984. Thus the base is a national probability sample of people age 55 and older living in the community. All respondents will be followed by linkage with death records through the National Death Index. Respondents age 65 and older will be followed by linkage with Medicare records. Respondents age 70 and older will be reinterviewed by telephone.

CONTENT: Interview will focus on changes in functioning, care giving, and living arrangements.

YEARS OF DATA COLLECTION: Baseline survey, 1984.
First reinterview, 1986.
Record linkage biannually.

PUBLICATIONS: Kovar, M.G. and J. Fitti, "A Linked Follow-up Study of Older People." *Proceedings of the Survey Research Section of the American Statistical Association*, 1985.

AVAILABILITY OF UNPUBLISHED DATA: None.

CONTACT: Mary Grace Kovar
(301) 436-7105

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Longitudinal Study of Aging (LSOA)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
x		Disability days
		Chronic limitations:
		of activity
		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
x		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
x		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **Longitudinal Study of Aging (LSOA)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in 1984 Sample	Nonresponse Rate
Total	17,000	
Under 65	8,000	
65-74	5,500	
75+	3,500	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x		
Geographic data			
Largest unit	U.S.		
Smallest unit	Region		
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Ambulatory Medical Care Survey (NAMCS)** Project Director: James DeLozier Chief, Ambulatory Care Statistics Branch National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	To provide general purpose statistics describing the public's use of office-based physician services, the health problems presented to physicians by ambulatory patients, and the diagnostic and therapeutic services received.
DESIGN:	Universe: all patient visits to office-based physicians in contiguous United States. Multistage sample design including 3,000 to 5,000 physicians in about 80 geographic areas. Probability sample, response of approximately 75%. Sample size 3,000 physicians, 50,000 patient visits through 1981. Sample size in 1985: 5,000 physicians, 75,000 visits.
CONTENT:	Information includes patient age, sex, race, ethnicity, and reason for visit; physician's diagnostic and therapeutic services ordered or provided; diagnosis and disposition decision and drugs prescribed. Variations from year to year are slight.
YEARS OF DATA COLLECTION:	Data collected annually from 1973 through 1981. Repeated in 1985 and scheduled on a triennial basis thereafter. 1985 data will be released in fall 1986.
PUBLICATIONS:	See advance data releases and Series 13: Data on Health Resources Utilization, National Center for Health Statistics.
AVAILABILITY OF UNPUBLISHED DATA:	Data are available in published and unpublished form as well as on public-use data tapes for all years in which survey has been completed. Data tapes are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, Ann Arbor, MI 48106. 1977--ICPSR 8046, 1978--8047, 1979--8048 Data tapes are also in the collection of the Duke University Data Archive for Aging and Adult Development (DAAAD), Durham, NC 27710.
CONTACT:	Raymond Gagnan NAMCS (301) 436-7132

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Ambulatory Medical Care Survey (NAMCS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Ambulatory Medical Care Survey (NAMCS)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	46,100 visits	20%
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	4 regions	4 regions	4 regions
Age classes			
Single years	x	x	
60-64			
65+			x
65-74, 75-84, 85+			x
Other			

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Death Index (NDI)**

Project Director: Robert Bilgrad
Special Assistant to the Director
Division of Vital Statistics
National Center for Health Statistics
3700 East-West Highway, Room 1-44
Hyattsville, MD 20782

PURPOSE: The National Death Index (NDI) is a computerized central file of death record information. It is compiled from magnetic tapes submitted to the National Center for Health Statistics (NCHS) by the state vital statistics offices. These tapes contain a standard set of identifying information for each decedent, beginning with deaths occurring in 1979.

Investigators conducting prospective and retrospective studies can use the NDI to determine whether persons in their studies may have died, and if so, be provided with the names of the states in which those deaths occurred, the dates of death, and the corresponding death certificate numbers. The NDI user can then arrange with the appropriate state offices to obtain copies of death certificates or specific statistical information such as cause of death.

DESIGN: The NDI file contains identifying death record information for virtually all deaths in the United States, Puerto Rico, and the Virgin Islands.

CONTENT: The identifying information on the NDI file is provided to NCHS on magnetic tapes submitted by the state vital statistics offices via contractual agreements. The items of information are: state of death, death certificate number, date of death, first and last name, middle initial, father's surname, social security number, date of birth, race, sex, marital status, state of residence, state of birth, age at death.

YEARS OF DATA COLLECTION: The NDI file contains 10.3 million death records for 1979-1983. Deaths are added to the file annually, approximately 12-14 months after the end of a calendar year. About 2 million records are added each year.

PUBLICATIONS: Patterson, J.E., and Bilgrad, R., The National Death Index Experience: 1981-1985 (Presented at the Workshop on Exact Matching Methodologies, Arlington, VA. May 1985). Includes published and unpublished references.

SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Death Index (NDI)**
	National Center for Health Statistics, DHHS User's Manual: The National Death Index, DHHS Pub. No. (PHS) 81-1148, September 1981.
AVAILABILITY OF UNPUBLISHED DATA:	The data on the NDI file are used solely for matching purposes to assist health investigators in their mortality ascertainment activities. The file is not used to generate statistics. The NDI file is confidential and copies are not available.
CONTACT:	Robert Bilgrad (301) 436-8951

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Death Index (NDI)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x		Identifying death record information

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Death Index (NDI)**

SELECTED ITEMS IN DATA SET

SIZE OF POPULATION

Age	Number in File	Nonresponse Rate
Total	10,289,958	
Under 60	2,448,436	
60+	7,841,522	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x *		
Social Security no.	x *		
Veteran status			
Geographic data			
Largest unit	State		
Smallest unit	County		
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

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* Available solely for matching purposes. Actual information is not disclosed.

SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Divorce Statistics**
	Project Director: Robert L. Heuser, Acting Chief Marriage and Divorce Statistics Branch Division of Vital Statistics National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	To collect demographic data on divorces, dissolutions of marriages, and annulments in the United States.
DESIGN:	Count of divorces granted from all states. Data on characteristics from sample of divorces occurring in states meeting criteria for divorce-registration area (31 states in 1982). Systematic sample designed to include at least 2,500 records from each state.
CONTENT:	Characteristics include: age, race, number of the marriage being dissolved, and education of husband and wife, place and duration of marriage, and number of children involved in the divorce.
YEARS OF DATA COLLECTION:	Divorce-registration area (DRA) established in 1958. Data collected annually.
PUBLICATIONS:	Vital Statistics of the United States, Vol. III, Marriage and Divorce. Periodic reports in Vital and Health Statistics, Series 21, published by the National Center for Health Statistics.
AVAILABILITY OF UNPUBLISHED DATA:	Public-use tapes for 1968 and subsequent years are available from National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.
CONTACT:	Robert L. Heuser (301) 436-8954

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Divorce Statistics**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
		Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
x	x	Divorce
		HOUSING
		Type of dwelling
x	x	No. of persons in household *
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* Children involved in divorce

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Divorce Statistics**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample *	Nonresponse Rate
Total	576,928	
Under 65	493,472 men	
	494,257 women	
65+	7,765 men	
	4,161 women	

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* Weighted numbers, DRA, 1982 (age distribution excludes cases with age not stated).

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	State	State	County (totals only)
Age classes			
Single years	x	x	
60-64			x
65+			x
65-74, 75-84, 85+			
Other			

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SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Health Interview Survey (NHIS): Core Questionnaire** Project Director: Stewart C. Rice, Jr. Chief, Survey Planning and Development Branch Division of Health Interview Statistics National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	To provide data on the incidence of acute conditions, limitation of activity, persons injured, hospitalizations, disability days, dental visits, physician visits, and the prevalence of selected chronic conditions.
DESIGN:	The NHIS is a continuing, nationwide, household interview survey. A probability sample of households in the civilian noninstitutionalized population of the United States is interviewed each week by interviewers from the Bureau of the Census. The sample consists of about 50,000 households representing about 130,000 persons. The NHIS "core" is not longitudinal and historically has not been linked to other files. An NHIS/National Death Index linkage capability was made possible after the 1984 NHIS survey year. In the future, beginning at the conclusion of the 1987 NHIS survey year, linkage capabilities will also exist between the NHIS, the National Medical Care Expenditure Survey, and the National Family Growth Survey.
CONTENT:	The NHIS provides current information on the amount, distribution, and effects of illness and disability in the United States, and the services rendered for or because of such conditions. The NHIS "core" has been virtually unchanged from year to year.
YEARS OF DATA COLLECTION:	Annually since 1957.
PUBLICATIONS:	Current Estimates, an annual publication of the basic statistics derived from the NHIS, is the primary publication. Other publications of specialized analyses are referenced as Series 10 reports in the Catalog of Publications of the National Center for Health Statistics.

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Core Questionnaire**

AVAILABILITY OF UNPUBLISHED DATA: Data are available both in public-use data tape form and in unpublished tabulations. Public-use data tapes are available through 1982. Unpublished tabulations exist for all years through 1982 and are on a variety of subjects relative to health status information. These data can be obtained by contacting the Division of Health Interview Statistics, National Center for Health Statistics.

Data tapes for 1970, 1975, 1977, 1978, 1979, and 1980 are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, Ann Arbor, MI 48106 (ICPSR 7838, 7672, 7839, 8044, 8049, 8223).

Data tapes are also in the collection of the Duke University Archive for Aging and Adult Development (DAAAD), Durham, NC 27710.

CONTACT:
Robert Fuchsberg
NCHS
(301) 436-7085

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Core Questionnaire**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x	x	Medicare Coverage
x	x	Medicaid Coverage
		State expenditures
x	x	Private insurance Coverage

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services (1968)
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
x	x	Prescription drugs (1965)
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Core Questionnaire**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	115,000 - 130,000	3-4%
Under 65	103,000 - 116,100	
65-74	7,500 - 8,500	
75+	4,800 - 5,400	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	Total U.S.	Total U.S.	Total U.S.
Smallest unit	4 regions	4 regions	4 regions
Age classes			
Single years			
60-64			
65+	x	x	x
65-74, 75-84, 85+			
Other			

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SPONSORS: National Center for Health Statistics (NCHS) and National Institute on Aging (NIA), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey: Data for the Study of Secular Change and Aging**

Project Director: Mary Grace Kovar
Interview and Examination Survey Program
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: To monitor the health of the U.S. population.

DESIGN: Sample of the civilian noninstitutionalized population. Response rate each year is greater than 95%.

CONTENT: Items that were on the core questionnaire of the National Health Interview Survey during the period 1969-81 will be abstracted and put in common format. There will be one record for each person age 30 and over.

YEARS OF DATA COLLECTION: 1969-81.

PUBLICATIONS: Vital and Health Statistics Series 10 is the primary publication. Description of sample and procedures is in Vital and Health Statistics Series 1, No. 18.

AVAILABILITY OF UNPUBLISHED DATA: Tape(s) will be a public-use data tape released through National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, VA 22151 and also through the National Archive of Computerized Data on Aging (NACDA), P.O Box 1248, Ann Arbor, MI 48106.

CONTACT: Mary Grace Kovar
(301) 436-7105

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SPONSORS: National Center for Health Statistics (NCHS) and National Institute on Aging (NIA), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey: Data for the Study of Secular Change and Aging**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
	x	No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
	x	Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
	x	of activity
		of mobility
	x	Impairments
	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSORS: National Center for Health Statistics (NCHS) and National Institute on Aging (NIA), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey: Data for the Study of Secular Change and Aging**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not available	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	
Smallest unit	States	Region	
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Supplement on Aging (SOA), 1984**

Project Director: Mary Grace Kovar
Interview and Examination Statistics Program
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: The National Health Interview Survey (NHIS) is a multipurpose national survey that is the principal source of information on the health of the civilian, noninstitutionalized population of the United States. It provides current statistical information on the amount, distribution, and effects of illness and disabilities in the United States and the services rendered for or because of such conditions. The Supplement on Aging (SOA) provides data on functional limitations and the health and social care received by the elderly, noninstitutionalized population, to complement the National Nursing Home Survey.

DESIGN: Persons ages 55 years and older in the 1984 NHIS household sample, which has a response rate of 97%, were selected for the SOA sample: 50% of NHIS respondents ages 55-64 and 100% of persons ages 65 and older were included. Response rate to the SOA was also 97%.

CONTENT: Health status, functional ability, health and community service utilization, employment status, social activities, family relationships and social support, housing characteristics and living arrangements, and existence of health conditions specific to the elderly population. The information in the supplement for each person can be associated with the basic health and condition information in the NHIS core questionnaire.

YEARS OF DATA COLLECTION: 1984 only.

PUBLICATIONS: None at this time. First publications will be in 1986.

AVAILABILITY OF UNPUBLISHED DATA: Public-use data tapes, expected to be available in 1986, can be obtained through the National Center for Health Statistics, Scientific and Technical Information Branch, 3700 East-West Highway, Hyattsvile, MD 20782.

CONTACT: Mary Grace Kovar
(301) 436-7105

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Supplement on Aging (SOA), 1984**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
X	X	Educational level
X	X	Race
X	X	Ethnicity
X	X	Sex
X	X	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
X	X	Type of dwelling
X	X	No. of persons in household
X	X	Relationship of persons in household
		INCOME AND WEALTH
X	X	Labor force participation
X	X	Total income
X	X	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
X	X	Acute and chronic conditions
X	X	Disability days
		Chronic limitations:
X	X	of activity
X	X	of mobility
		Impairments
X	X	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
X	X	Social interaction
X	X	Activities of daily living
X	X	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER FISCAL CATEGORY FOR SAMPLING UNIT

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Supplement on Aging (SOA), 1984**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	17,000	3%
Under 65	8,000	
65-74	5,500	
75+	3,500	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	Total U.S.	Total U.S.	Total U.S.
Smallest unit	4 regions	4 regions	4 regions
Age classes			
Single years	x	x	x
60-64			
65+	x	x	x
65-74, 75-84, 85+			
Other			

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Supplements**

Project Director: Stewart C. Rice
Chief, Survey Planning and Development Branch
Division of Health Interview Statistics,
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: To provide data, in addition to the basic NHIS data, on special topic areas pertinent to the aging population, such as living arrangements, activities of daily living (ADL), instrumental activities of daily living (IADL), retirement status, support systems, etc.

DESIGN: The universe studied are those persons in the U.S. non-institutionalized civilian population in the age categories of interest, as represented by persons in those age categories in the NHIS probability sample of households.

CONTENT: Supplements to the NHIS have been conducted annually for the past 20 years. Topics of coverage in the supplement vary from year to year and may or may not apply to the aging population. Among those that include or are designed specifically for an aging population are:

Arthritis--1969, 1976.
Residential mobility--1979, 1980.
Hearing aid--1971, 1977, 1979.
Visual and hearing impairment--1971, 1977, 1984.
Edentulousness--1971.
Home care--1979, 1980.
Supplement on aging--1984.

YEARS OF DATA COLLECTION: See Content.

PUBLICATIONS: NCHS Series 10 publications in the Catalog of Publications of the National Center for Health Statistics.

AVAILABILITY OF UNPUBLISHED DATA: Public-use data tapes are available for all supplements through 1983. Requests should be directed to the Scientific and Technical Information Branch, National Center for Health Statistics, 3700 East-West Highway, Hyattsville, MD 20782.

CONTACT: Robert Fuchsberg
NCHS
(301) 436-7085

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Supplements**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
x	x	Total income (family)
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

Note: Among all the NHIS Supplements there are included items on almost every type of data cited in this list.

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health Interview Survey (NHIS): Supplements**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE*

Age	Number in Sample	Nonresponse Rate
Total		
Under 65		
65-74		
75-84		
85+		

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* Sample sizes vary by supplement.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	Total U.S.	Total U.S.	Total U.S.
Smallest unit	4 regions	4 regions	4 regions
Age classes			
Single years			
60-64			
65+	x	x	x
65-74, 75-84, 85+			
Other			

SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Health and Nutrition Examination Survey (NHANES I)**
	Project Director: Robert S. Murphy, Director Division of Health Examination Statistics Center Building, Room 2-58 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	Established under the National Health Survey Act of 1956 to obtain those kinds of health data optimally obtained by direct physical examinations and physiological and biochemical measurements. Measures and monitors health and nutritional status of the U.S. population. Permits estimation of the prevalence of certain diseases and the distributions of a broad variety of health-related measurements.
DESIGN:	Probability sample of the U.S. civilian noninstitutionalized population ages 1 through 74 years. Cross-sectional study of 31,973 persons of whom 23,808 were examined. Composed of two overlapping sets of examination components referred to as the nutrition examination and the detailed medical examination. Six distinct probability samples were contained within the overall survey. This study was used as the baseline for a later study called the NHANES I Epidemiologic Follow-up Survey.
CONTENT:	Demographic information; medical histories; dietary information; electrocardiograms; body measurements; dermatological and ophthalmological examinations; general medical examination; hematological, blood chemistry, and urological laboratory determinations. In the detailed medical examination, additional data were collected on a subsample of adults 25-74 years by supplementary questionnaires concerning arthritis, respiratory conditions, and cardiovascular conditions; an extended medical examination, x-rays of the chest for heart size and pathology as well as lung volume and pathology; x-rays of the hip, sacroiliac, and knee joints for assessment of arthritic and related changes; spirometry and additional laboratory determinations.
YEARS OF DATA COLLECTION:	1971 to 1975. NHANES II was conducted from 1976 to 1980.
PUBLICATIONS:	National Center for Health Statistics: Plan and operation of the Health and Nutrition Examination Survey, United States, 1971-1973. H.W. Miller. Vital and Health Statistics. DHEW Pub. No. (PHS) 79-1310. Series 1, Nos. 10A and 10B. December 1978.

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health and Nutrition Examination Survey (NHANES I)**

PUBLICATIONS: National Center for Health Statistics: Plan and operation of the NHANES I Augmentation Survey of Adults 25-74 years, United States, 1974-1975. A. Engel, R.S. Murphy, K. Maurer, and E. Collins. Vital and Health Statistics. DHEW Pub. No. (PHS) 78-1314. Series 1, No. 14. June 1978.

See also Catalog of Publications from the National Center for Health Statistics. Publications listed in Series 11 of Vital and Health Statistics.

AVAILABILITY OF UNPUBLISHED DATA: Data tapes are available on virtually all the information collected in NHANES I. A catalog is available from the Scientific and Technical Information Branch, National Center for Health Statistics, Room 1-57, 3700 East-West Highway, Hyattsville, MD 20782.

Data collected in the HANES surveys can be located by means of HINDEX, available in hard copy or on a floppy diskette. Each line of HINDEX contains information on an individual data item, giving its contents, classification, method by which the data was obtained, the age range for which it was collected, the survey year in which it was collected, and the location of the data item on the tape. HINDEX has been released in three volumes: one indexes the data items in alphabetical sort by data category; the second is an alphabetical sort by data field; and the third, a numerical sort by tape and position field.

Data tapes for the First National Health and Nutrition Examination Survey (NHANES I) are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

CONTACT: Patricia A. Vaive
NCHS
(301) 436-7080

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health and Nutrition Examination Survey (NHANES I)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
x	x	Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	Examination findings
x	x	Nutritional status

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Health and Nutrition Examination Survey (NHANES I)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample*	Nonresponse Rate*
Total	28,043	26.1%
Under 65	22,651	23.7%
65-74	5,392	35.7%

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* Numbers and rates apply to the largest of the NHANES I subsamples, the 65 location nutrition examination sample.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	National	National	National
Smallest unit	County	Region	National
Age classes			
Single years	x	x	
60-64	x	x	
65+	x	x	
65-74, 75-84, 85+	65-74	65-74	65-74
Other	1-74 years	1-74 years	10-year age intervals

SPONSORS:	National Center for Health Statistics (NCHS) with National Institute on Aging and other Institutes
TITLE:	**NHANES I Epidemiologic Follow-up Study: Initial Follow-up, 1982-84**
	Project Director: Helen E. Barbano Special Assistant Division of Analysis National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	Identify chronic disease risk factors associated with morbidity and mortality; ascertain changes in risk factors, morbidity, functional limitation and institutionalization between NHANES I and the follow-up recontacts; and map the natural history of chronic diseases and functional impairments in an aging population.
DESIGN:	The baseline survey, the first National Health and Nutrition Examination Survey (NHANES) conducted by NCHS from 1971 to 1975 was a probability sample of the civilian noninstitutionalized coterminous U.S. population ages 1-74 years. The population of the follow-up study includes the 14,407 persons who were ages 25-74 at the time they were examined in the original NHANES I Survey.
CONTENT:	See Types of Data Collected.
YEARS OF DATA COLLECTIONS:	The NHANES I Epidemiologic Follow-up Study: initial follow-up 1982-84; data tapes will be available in early 1987. Continued follow-up of the elderly 1985-86; data tapes will be available in 1989. Continued follow-up of total sample 1986-87; data tapes will be available in 1990.
PUBLICATIONS:	Cornoni-Huntley, J., Barbano, H.E., Brody, J.A., Cohen, B., Feldman, J.J., Kleinman, J.C., and Madans, J., National Health and Nutrition Examination Survey--Epidemiologic Follow-up Survey. Public Health Reports 98:245-251.
AVAILABILITY OF UNPUBLISHED DATA:	While data tapes are being cleaned up, collaborators from National Institute on Aging, other National Institutes of Health, and the Alcohol, Drug Abuse, and Mental Health Administration are using data tapes. Public-use data tapes available beginning in 1987.
CONTACT:	Jennifer Madans NCHS (301) 436-5975

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SPONSORS: National Center for Health Statistics (NCHS) with National Institute on Aging and other Institutes

TITLE: **NHANES I Epidemiologic Follow-up Study: Initial Follow-up, 1982-84**

TYPES OF DATA COLLECTED

Data File*	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
x		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File*	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
		Behavior problems
x		Depression
x		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction (limited)
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION **
x		General hospital services
x		Nursing home services
		Home health care
x		Rehabilitation
x		Mental health hospitalization
		Mental health outpatient services
x		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
x		Prescription drugs (selected)
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* Initial follow-up

** Inpatient only

SPONSORS: National Center for Health Statistics (NCHS) with National Institute on Aging and other Institutes

TITLE: **NHANES I Epidemiologic Follow-up Study: Initial Follow-up 1982-84**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age *	Number in Sample			Nonresponse Rate **
		% Traced	% Deceased	
Total	14,407	93	14.5	6.8%
Under 65	10,549	84	6.0	6.6%
65+	3,858	97	37.8	7.8%

Age	Sample for whom we have interview data ***
Total	85%
Under 65	84%
65+	86%

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* At time of sample selection in 1971-75; interviewed in 1982-83.

** Percentage of sample located alive not responding to questionnaire (includes refusal and subjects living outside the coterminous U.S.).

*** Includes proxy for deceased or incapacitated.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	
Smallest unit	Cluster of counties	Region (4)	
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**NHANES II, Second National Health and Nutrition Examination Survey**
	Project Director: Robert S. Murphy, Director Division of Health Examination Statistics Center Building, Room 2-58 National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	Established under the National Health Survey Act of 1956 to obtain those kinds of health data optimally obtained by direct physical examinations and physiological and biochemical measurements. Measures and monitors health and nutritional status of the U.S. population. Permits estimation of the prevalence of certain diseases and the distributions of a broad variety of health-related measurements.
DESIGN:	Probability sample of the U.S. civilian noninstitutionalized population ages 6 months to 74 years. Cross-sectional study of 27,801 persons of whom 20,322 (73.1%) were interviewed and examined.
CONTENT:	Demographic information, medical histories, dietary information, electrocardiograms, body measurements, allergy test results, x-rays of chest and cervical and lumbar spine, glucose tolerance test results, liver function and anemia testing results, lipid testing results, pesticide test results, and hematology tests. Target conditions included diabetes, kidney pathology, liver disease, allergy, osteoarthritis and disc degeneration, cardiovascular conditions, and body burdens of carbon monoxide, lead, and pesticide residues.
YEARS OF DATA COLLECTION:	NHANES II was conducted from February 1976 to February 1980. Current plans are under way for a NHANES III to be fielded in 1988.
PUBLICATIONS:	National Center for Health Statistics, Plan and Operation of the Second National Health and Nutrition Examination Survey, 1976-1980. McDowell et al. Vital and Health Statistics. Series 1-No. 15 DHHS Pub. No. (PHS) 81-1317. July 1981.
	See also Catalog of Publications from the National Center for Health Statistics. Publications listed in Series 11 of Vital and Health Statistics.

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **NHANES II, Second National Health and Nutrition Examination Survey**

AVAILABILITY OF UNPUBLISHED DATA: Data tapes are available on a major portion of the information collected in NHANES II. A catalog is available from the Scientific and Technical Information Branch, National Center for Health Statistics, Room 1-57, 3700 East-West Highway, Hyattsville, MD 20782.

Data collected in the HANES surveys can be located by means of HINDEX, available in hard copy or on a floppy diskette. Each line of HINDEX contains information on an individual data item, giving its contents, classification, method by which the data was obtained, the age range for which it was collected, the survey year in which it was collected, and the location of the data item on the tape. HINDEX has been released in three volumes: one indexes the data items in alphabetical sort by data category; the second is an alphabetical sort by data field; and the third, a numerical sort by tape and position field.

Data tapes for the Second National Health and Nutrition Examination Survey (NHANES II) are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

CONTACT: Patricia A. Vaive
NCHS
(301) 436-7080

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **NHANES II, Second National Health and Nutrition Examination Survey**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
x	x	Other--Some condition-specific utilization data
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
x	x	Examination findings
x	x	Nutritional status

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **NHANES II, Second National Health and Nutrition Examination Survey**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	27,801	27%
Under 65	23,589	25%
65-74	4,212	38%

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	National	National	National
Smallest unit	County	Region	National
Age classes			
Single years	x	x	
60-64	x	x	
65+	x	x	
65-74, 75-84, 85+	65-74	65-74	65-74
Other	6 mos-74 yrs	6 mos-74 yrs	10-year age intervals

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Hospital Discharge Survey (NHDS)**

Project Director: Mary Moien
Chief, Hospital Care Statistics Branch
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: The survey provides information on the utilization of short-stay nonfederal hospitals in the United States. Only hospitals with six or more beds are included.

DESIGN: The sample is a two-stage stratified probability sample of hospitals and patients within hospitals. Stage 1 includes a 10% sample of all short-stay nonfederal hospitals, and stage 2 includes a sample of discharges. Approximately 200,000 records per year are collected and weighted up to national estimates. The nonresponse rate is approximately 15% in the last 10 years and less before that.

CONTENT: Data on medical record abstracts for discharges from hospitals are collected for patient age, sex, race, marital status, disposition; patient's length of stay and (since 1977) expected source of payment; and diagnoses and surgical procedures. Information is available on size, ownership, and region of country of hospital.

YEARS OF DATA COLLECTION: Annually since 1965. 1984 is most recent year for which data are available.

PUBLICATIONS: Annual data are published in NCHS, Advance Data series, in NCHS Vital and Health Statistics Series 13, and in Special Reports.

AVAILABILITY OF UNPUBLISHED DATA: Unpublished data are available from 1965 to 1984. Data tapes are available for 1970-1983 from National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22101. Telephone: (703) 487-4763.

CONTACT: Hospital Care Statistics Branch
(301) 436-7125

SPONSOR. National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Hospital Discharge Survey (NHDS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
x	x	Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Hospital Discharge Survey (NHDS)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE Per Year

Age	Number in Sample* (Approximate)	Nonresponse Rate
Total	200,000	15%
Under 65	150,000	
65-74	27,000	
75-84	21,000	
85+	7,500	

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* Weighted up to national estimates.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth or age	x	x	x
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	Division	Division	Usually region
Age classes			
Single years	x	x	
60-64			
65+			x
65-74, 75-84, 85+			x
Other			

SPONSORS: National Center for Health Statistics (NCHS), National Heart, Lung, and Blood Institute (NHLBI), and Bureau of the Census

TITLE: **National Longitudinal Mortality Study**

Project Director:
Diane Makuc
Chief, Analytical Coordination Branch
Division of Analysis
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

Investigators:
Eugene Rogot, Statistician
National Heart, Lung, and Blood Institute
Federal Building, Room 2C-08
Bethesda, MD 20892

Norman Johnson, Mathematical Statistician
Bureau of the Census, Room 3725-3
Washington, DC 20233

Marilyn McMillen, Statistician
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: To study socioeconomic differentials in mortality.

DESIGN: Universe--noninstitutionalized population of the United States sampled through the Current Population Survey (CPS).

Records for about 1 million persons included in several CPS samples (March, 1973; February 1978; March 1979; April, August, December, 1980; March 1981-1983) are being linked to the National Death Index to identify deaths. Cause of death is obtained for all deaths.

CONTENT: The information collected is all CPS data (socioeconomic, demographic, labor force participation information) and death certificate data for all deaths. The March CPS files contain more detailed information on income, occupation, and labor force participation than other CPS files.

YEARS OF DATA COLLECTION: CPS data--1973, 1978, 1979, 1980, 1981, 1982, 1983. Mortality data--1979-1983. Additional data for 1984-85 have been budgeted.

PUBLICATIONS: Makuc et al., An Overview of the U.S. National Longitudinal Mortality Study. 1984 ASA Proceedings of the Social Statistics Section.

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SPONSORS: National Center for Health Statistics (NCHS), National Heart, Lung, and Blood Institute (NHLBI), and Bureau of the Census

TITLE: **National Longitudinal Mortality Study**

Rogot et al. On the feasibility of linking Census samples to the NDI for epidemiologic studies AJPH. Vol. 73, No. 11, November 1983, 1265-69.

Rogot et al. Mortality by cause of death among selected Census Bureau sample cohorts, 1979-81; 1985 ASA Proceedings of the Social Statistics Section.

AVAILABILITY OF UNPUBLISHED DATA: In-house tapes now being developed for use of sponsors. Future plans not yet determined.

CONTACT: Diane Makuc
(301) 436-5975

SPONSORS: National Center for Health Statistics (NCHS), National Heart, Lung and Blood Institute (NHLBI), and Bureau of the Census

TITLE: **National Longitudinal Mortality Study**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
x		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
x		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions*
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* Cause of death

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SPONSORS:	The National Center for Health Statistics (NCHS), National Heart, Lung and Blood Institute (NHLBI), and Bureau of the Census
TITLE:	**National Longitudinal Mortality Study**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Approximate Number in all CPS Samples	Nonresponse Rate
Total	1,000,000	
Under 65	896,000	
65+	104,000	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x		
Geographic data			
Largest unit	U.S.		
Smallest unit			
Age classes			
Single years	x		
60-64	x		
65+	x		
65-74, 75-84, 85+	x		
Other			

SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Marriage Statistics**
	Project Director: Robert L. Heuser Acting Chief, Marriage and Divorce Statistics Branch Division of Vital Statistics National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	To collect demographic data on marriages performed in the United States.
DESIGN:	Count of marriages performed from all states. Data on characteristics from sample of marriages occurring in states meeting criteria for marriage-registration area (42 states and the District of Columbia in 1982). Systematic sample designed to include at least 2,500 records from each state.
CONTENT:	Characteristics include: age, race, number of the marriage, previous marital status, interval since last marriage, and education of the bride and groom; type of ceremony (civil or religious).
YEARS OF DATA COLLECTION:	Marriage-registration area (MRA) established in 1957. Data collected annually.
PUBLICATIONS:	Vital Statistics of the United States, Vol. III, Marriage and Divorce. Periodic reports in Vital and Health Statistics, Series 21, published by the National Center for Health Statistics.
AVAILABILITY OF UNPUBLISHED DATA:	Public-use data tapes for 1968 and subsequent years are available from National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.
CONTACT:	Robert L. Heuser (301) 436-8954

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Marriage Statistics**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
		Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x	x	Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Marriage Statistics**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample*	Nonresponse Rate
Total	1,912,684	
Under 65	1,894,391 women	
Under 65	1,878,820 men	
65-85+	18,293 women	
	33,864 men	

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* Weighted numbers, MRA, 1982.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	MRA	MRA	U.S.
Smallest unit	State	State	County (totals)
Age classes			
Single years	x	x	
60-64			
65+			x
65-74, 75-84, 85+			
Other			

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SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Master Facility Inventory (NMFI)** Project Director: Evelyn S. Mathis Chief, Long-Term Care Statistics Branch National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	The NMFI has two basic purposes. It is an important national source of statistics on the number, type, and geographic distribution of inpatient facilities in the United States. In addition, it serves as the universe from which probability samples are selected for conducting sample surveys.
DESIGN:	The NMFI is a comprehensive file of all facilities in the United States with three or more beds that provide medical, nursing, personal, or custodial care to groups of unrelated persons on an inpatient basis. Facilities are categorized into three broad types: hospitals, nursing and related care homes, and other custodial or remedial care facilities.
CONTENT:	Basically, the types of data collected for the three categories of facilities are: ownership; major type of service; number of beds; patient census; number of admissions, discharges, and deaths; and information about staffing, revenue, and expenses.
YEARS OF DATA COLLECTION:	Data were collected for the following years: 1963, 1967, 1969, 1971, 1973, 1976, 1978, 1980, 1982. The first report on data from the 1982 survey was published in September 1985; the second will be published during 1986. Because an evaluation of the NMFI program is under way, the inventory will not be conducted before 1988.
PUBLICATIONS:	Data from the NMFI are published in Health-United States and in Vital and Health Statistics, Series 14.
AVAILABILITY OF UNPUBLISHED DATA:	Data are available in the form of public-use tapes for all years. These tapes can be obtained from the National Technical Information Service, Springfield, VA 22161. Additional data are released in the form of special tabulations prepared specifically for individual requestors. Data tapes for the 1976 National Master Facility Inventory are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106 (ICPSR 9630 and 7631).
CONTACT:	Al Sirrocco NCHS (301) 436-8830

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Master Facility Inventory (NMFI)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
*	*	General hospitals
*	*	Private psychiatric hospitals
*	*	Public mental health hospitals
x	x	Nursing homes
x	x	Other institutional resources
x	x	Community-based resources
x	x	Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
*	*	General hospital services
x	x	Nursing home services
		Home health care
		Rehabilitation
*	*	Mental health hospitalization
		Mental health outpatient services
*	*	Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* These facilities are on files from 1963-1976 only.

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Master Facility Inventory (NMFI)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

	Number in Universe	Nonresponse Rate
* Hospitals	6,915	10.3%
Nursing Homes	17,819	4%

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* Hospital data provided by the American Hospital Association.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	Zip code	Zip code	State
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSORS: National Center for Health Statistics (NCHS) and Health Care Financing Administration (HCFA)

TITLE: **National Medical Care Utilization and Expenditure Survey (NMCUES), 1980**

Project Director:
Robert A. Wright
Chief, Utilization and Expenditures
Statistics Branch
Division of Health Interview Statistics
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782
and
Herbert A. Silverman
Chief, Program Statistics Branch
Office of Research and Demonstrations
Health Care Financing Administration
6325 Security Boulevard
Baltimore, MD 21207

PURPOSE: NMCUES is designed to be directly responsive to the continuing need for statistical information on the health care expenditures associated with health services utilization for the entire U.S. population. Cycle 1 was designed and conducted in collaboration with the Health Care Financing Administration to provide detailed utilization and expenditure data for persons in the Medicare and Medicaid populations. MMCUES will produce estimates over time for evaluation of the impact of legislation and programs on health status, costs, utilization and illness-related behavior in the medical care delivery system.

Cycle 1 was composed of several related surveys. The household portion of the survey consisted of a national survey of the civilian noninstitutionalized population and a separate survey of the Medicaid-eligible populations of the states of New York, California, Texas, and Michigan. These two surveys each consisted of five interviews over a period of about 15 months to obtain information on medical care utilization, expenditures, and other health-related information. A third survey, an administrative records survey, was designed to verify the eligibility status of the household survey respondents for the Medicare and Medicaid programs. It also checked insurance claims filed with the national Medicare program and Medicaid programs in each of the four states for persons in the sample of Medicaid eligibles.

DESIGN: The national Cycle 1 household survey comprised persons residing in about 6,000 households. The sample for this survey was a multistage area probability sample drawn from 106 primary sampling units representing the 50 states and the District of Columbia. The state Medicaid household survey sample consisted of about 1,000 families in each of

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SPONSORS: National Center for Health Statistics (NCHS) and Health Care Financing Administration (HCFA)

TITLE: **National Medical Care Utilization and Expenditure Survey (NMCUES), 1980**

the four states; these families were selected with a known probability of selection from the state Medicaid enrollment lists. Thus, the total sample for the survey was about 10,000 households.

An overall response rate of 89.4% was achieved in the first interview for both household surveys in Cycle 1: for the national survey the response rate was 91.4%, and for the state Medicaid survey the rate was 86.7%. Attrition over the course of interviewing resulted in final response rates of 84.9% for the national household survey and 76.1% for the state Medicaid household survey.

CONTENT: Questionnaires for the household surveys were designed to obtain some information on a repeated basis throughout the survey and some information only one time. The repetitive core of questions for Cycle 1 included health insurance coverage, episodes of illness, the number of bed days, restricted activity days, hospital admissions, physician and dental visits, other medical care encounters, and purchases of prescribed medicines. For each contact with the medical care system, data were obtained on the nature of the health conditions, characteristics of the provider, services provided, charges, sources, and amounts of payment. Questions asked only once included data on access to medical care services, limitation of activities, occupation, income, and other sociodemographic characteristics.

YEARS OF DATA COLLECTION: 1980.

PUBLICATIONS: See National Medical Care Utilization and Expenditure Survey, Data Reports Series and Methodological Reports Series, National Center for Health Statistics, and Descriptive Reports Series and Analytic Report Series issued by Office of Research and Demonstrations, Health Care Financing Administration.

AVAILABILITY OF UNPUBLISHED DATA: Public-use tapes available from National Technical Information Service (NTIS). Data tapes are also in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106 (ICPSR 8239).

CONTACT: Robert A. Wright
(301) 436-7100

SPONSORS: National Center for Health Statistics (NCHS) and Health Care Financing Administration (HCFA)

TITLE: **National Medical Care Utilization and Expenditure Survey (NMCUES), 1980**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
X	X	Educational level
X	X	Race
X	X	Ethnicity
X	X	Sex
X	X	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
X	X	No. of persons in household
X	X	Relationship of persons in household
		INCOME AND WEALTH
X	X	Labor force participation
X	X	Total income
X	X	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
X	X	Costs of care
X	X	Out-of-pocket costs
X	X	Medicare
X	X	Medicaid
		State expenditures
X	X	Private insurance

Data File	Public-Use Tape	
		HEALTH
X	X	Acute and chronic conditions
X	X	Disability days
		Chronic limitations:
X	X	of activity
X	X	of mobility
X	X	Impairments
X	X	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
X	X	General hospital services
		Nursing home services
X	X	Home health care
		Rehabilitation
		Mental health hospitalization
X	X	Mental health outpatient services
		Alcohol and drug abuse centers
X	X	Physician services/visits
X	X	Dental services/visits
X	X	Prescription drugs
X	X	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSORS: National Center for Health Statistics (NCHS) and Health Care Financing Administration (HCFA)

TITLE: **National Medical Care Utilization and Expenditure Survey (NMCUES), 1980**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	17,123	approx. 12%
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	4 regions	4 regions	4 regions
Age classes			
Single years	x	x	
60-64			
65+	x	x	x
65-74, 75-84, 85+	x	x	x
Other			

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Mortality Followback Surveys**

Project Director: Sam Seeman
Project Manager
National Mortality Followback Survey
Office of Vital and Health Care Statistics
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: To expand knowledge about the mortality experience of the U.S. population, without burdening the ongoing state and national vital statistics registration system.

DESIGN: Data sources: next of kin of the decedents, identified as the informants on the death certificate. Hospitals, nursing homes, and other facilities used by the decedent in the last year of life.

A systematic sample of all deaths in the United States.

1961 n = 5,145; nonresponse 7%
1962-63 n = 10,822; nonresponse 8%
1964-65 n = 10,408; nonresponse 9%
1966-68 n = 19,526; nonresponse 8%
1986 survey planned; pretest under way in 1985.

CONTENT:

1961	Utilization of hospitals and institutions during the last year of life.
1962-63	Utilization of hospitals and institutions in the last year of life; household composition, education, income, residence.
1964-65	Utilization; hospital and surgical insurance coverage, charges for hospital care and source of payment, surgeon's bills and source of payment, household composition, assets, and income.
1966-68	Utilization; family composition, smoking habits.
1986	Care in the last year of life; life-style habits and risk factors; socioeconomic status; reliability of selected items reported on the death certificate.

YEARS OF DATA COLLECTION:
1961
1962-63
1964-65
1966-68
1986

Future surveys to be conducted periodically; at least every 6 years, perhaps more frequently.

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Mortality Followback Surveys**

PUBLICATIONS: National Center for Health Statistics, *Hospitalization in the Last Year of Life*. Vital and Health Statistics. Series 22, No. 1. U.S. Department of Health, Education and Welfare, Washington, D.C. September 1965.

National Center for Health Statistics, *Episodes and Duration of Hospitalization in the Last Year of Life. United States--1961*. Vital and Health Statistics. Series 22, No. 2. U.S. Department of Health, Education, and Welfare, Washington, D.C. June 1966.

National Center for Health Statistics, *Socioeconomic Characteristics of Deceased Persons, United States, 1962-1963*. Vital and Health Statistics. Series 22, No. 9. U.S. Department of Health, Education, and Welfare, Washington, D.C. February 1969.

National Center for Health Statistics, *Health Insurance Coverage of Adults Who Died in 1964 or 1965, United States*. U.S. Department of Health, Education, and Welfare, Washington, D.C. October 1969. Series 22, No. 10.

AVAILABILITY OF UNPUBLISHED DATA: Public-use tape for 1966-68 and future surveys. Unpublished data for prior surveys available through the National Center for Health Statistics.

CONTACT: Sam Seeman
(301) 436-7107

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Mortality Followback Surveys**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x	x	Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
		Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
		Sources of income
x	x	Net assets
Limited		**SOCIAL SERVICES**
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
Limited		Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
x	x	Behavior problems
		Depression
x	x	Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x	x	Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION*
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
		Rehabilitation
x	x	Mental health hospitalization
x	x	Mental health outpatient services
x	x	Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* Utilization in last year of life

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Mortality Followback Surveys**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample*	Nonresponse Rate
Total	20,000	
Under 65		
65-74		
75-84		
85+		

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* Sample--25 years and over.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.	x		
Veteran status	x	x	
Geographic data			
Largest unit	U.S.		
Smallest unit	U.S.		
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR:	National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)
TITLE:	**National Mortality Statistics File**
	Project Director: Harry M. Rosenberg Chief, Mortality Statistics Branch Division of Vital Statistics National Center for Health Statistics 3700 East-West Highway Hyattsville, MD 20782
PURPOSE:	To produce uniform national, state, and local data on numbers of deaths, causes of death, and sociodemographic characteristics of decedents.
DESIGN:	Mortality data include all deaths (approximately 2 million) occurring annually within the United States reported to state vital registration offices. In 1972, a 50% sample of mortality data was used; generally, however, 100% of deaths are included. Data are collected annually. Data are available for the entire U.S. annually since 1933 and for selected states since 1900.
CONTENT:	Demographic and medical information is coded from information reported on the death certificate including residence, age, race, sex, underlying cause of death, and multiple causes of death.
YEARS OF DATA COLLECTION:	Data are collected annually. Data through 1983 are available and will be published in annual volumes of Vital Statistics of the United States, Vol. II, "Mortality," Parts A and B. Summary counts of deaths by age, race, sex, and cause are available on a current basis in Monthly Vital Statistics Report, as are provisional monthly counts of deaths by cause.
PUBLICATIONS:	Vital Statistics of the United States, Volume II, "Mortality," Parts A and B; Monthly Vital Statistics Report, National Center for Health Statistics.
AVAILABILITY OF UNPUBLISHED DATA:	Public-use data tapes are available for data years 1968-83 and can be obtained from the National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161. Mortality Detail Files, 1969-1983 (ICPSR 7632) are also in the collection of the National Archive of Computerized Data on Aging maintained by the Inter- university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.
CONTACT:	Harry M. Rosenberg (301) 436-8884

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Mortality Statistics File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x	x	Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
*	*	Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* Cause of death

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Mortality Statistics File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of Deaths, 1983	Nonresponse Rate
Total	2,000,000	
Under 65	559,000	
65-74	489,000	
75-84	554,000	
85+	398,000	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	10,000+pop.	100,000+pop.	10,000+pop.
Age classes			
Single years	x	x	x
60-64			x
65+			x
65-74, 75-84, 85+			x
Other			

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Natality Statistics**

Project Director: Robert L. Heuser
Chief, Natality Statistics Branch
Division of Vital Statistics
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: To collect demographic and health data on births for use in the study of fertility and in the planning and evaluation of health programs.

DESIGN: Data are obtained from live-birth certificates collected by state vital registration offices. For some years data are based on 50% systematic sample; for some years on a 100% sample; and for some years a combination of 50% and 100% samples.

CONTENT: Demographic and health characteristics including age of mother, live-birth order, race, sex, plurality, marital status and education of mother, residence, birth weight, length of gestation, prenatal care, attendant at delivery, and in- or out-of-hospital delivery.

YEARS OF DATA COLLECTION: Annual. National data available since 1933.

PUBLICATIONS: Vital Statistics of the United States, Vol. I, Natality. Periodic reports in Vital and Health Statistics, Series 21, published by the National Center for Health Statistics.

AVAILABILITY OF UNPUBLISHED DATA: Public-use data tapes for 1968 and subsequent years are available from National Technical Information Service, 5285 Port Royal Road, Springfield, VA 22161.

CONTACT: Robert L. Heuser
(301) 436-8954

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Natality Statistics**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
x	x	Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Natality Statistics**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of births	Nonresponse Rate
Total	3,680,537 (1982)	Est. 99.3% registration completeness

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	County/City of 10,000 or more population	x	x
Age classes			
Single years (Age of mother)	x	x	x

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Nursing Home Survey (NNHS)**

Project Director: Joan F. Van Nostrand
Deputy Director
Division of Health Care Statistics
National Center for Health Statistics
3700 East-West Highway
Hyattsville, MD 20782

PURPOSE: To collect data on nursing homes, their services, staffs, and financial characteristics, and on personal and health characteristics of residents and discharges.

DESIGN: Data are collected from a sample of all nursing homes in the coterminous United States (1,200 nursing homes listed in the Master Facility Inventory). Samples in each nursing home are selected of current residents, persons discharged (deceased or alive in the last year), and staff members. Data on residents and discharges are collected by interviewing the nurse who obtains the needed information from the medical records and the next of kin. Estimates are produced for the United States, census regions, and DHHS regions, and in 1977 for five states with the largest nursing home populations.

CONTENT: The survey collects data on characteristics of the facility and its finances, of residents, of discharges, and of staff, as follows:

Facility: size, ownership, Medicare and Medicaid certification, staffing patterns, and services offered.
Financial characteristics: Total expenses and major components of operation.
Residents: Demographic characteristics, living arrangements prior to admission, diagnosis and conditions, functional status, receipt of services (medical, nursing, and therapeutic), cost of care, source of payment.
Discharges: A subset of items collected for current residents available from the record.
Staff: Data varied with survey. In 1985 survey, characteristics of registered nurses--work schedule, experience, activities in facility, demographic characteristics, and salary were collected.
Next of kin: Information about residents' and discharges' living arrangements, health and functional status prior to nursing home admission, lifetime use of nursing home care, Medicaid spend-down.

YEARS OF DATA COLLECTION: 1973-74, 1977, 1985, and proposed for 1990.

PUBLICATIONS: NCHS Series 13 for utilization and patient characteristics.
NCHS Series 14 for staffing characteristics.

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

Title: **National Nursing Home Survey (NNHS)**

AVAILABILITY OF UNPUBLISHED DATA: Public-use tapes available through NCHS Scientific and Technical Information Branch, 3700 East-West Highway Hyattsville, MD 20782, and NTIS, 5285 Port Royal Road, Springfield, VA 22161. With the exception of individual or establishment identifiers, all data collected are available on the public use data tape. Data tapes are in the collection of the National Archives of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, Box 1248, Ann Arbor, MI 48106 (ICPSR 7946).

Data tapes are also in the collection of the Duke University Data Archive for Aging and Adult Development (DAAAD), Box 3003, Duke University Medical Center, Durham, NC 27710.

CONTACT: Joan F. Van Nostrand
(301) 436-8422

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Nursing Home Survey (NNHS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
X	X	Race
X	X	Ethnicity
X	X	Sex
X	X	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
X	X	Mortality
		Marriage
		Divorce
		HOUSING
X	X	Type of dwelling
X	X	No. of persons in household
X	X	Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
X	X	Costs of care
X	X	Out-of-pocket costs
X	X	Medicare
X	X	Medicaid
		State expenditures
X	X	Private insurance

Data File	Public-Use Tape	
		HEALTH
X	X	Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
X	X	Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
X	X	Behavior problems
X	X	Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
X	X	Morbidity
X	X	Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
X	X	Social interaction
X	X	Activities of daily living
X	X	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
X	X	General hospital services
X	X	Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
X	X	Physician services/visits
		Dental services/visits
X	X	Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Center for Health Statistics (NCHS), Department of Health and Human Services (DHHS)

TITLE: **National Nursing Home Survey (NNHS)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE*

Age	Number of Residents in Sample	Nonresponse Rate
Total	7,033	2%
Under 65	939	
65-74	1,130	
75-84	2,509	
85+	2,455	

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* Discharge sample about 6,000.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public Use Tape	Published Tables
Date of birth	x	x	
Social Security no.	x (only in 1985)		
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	DHHS regions	DHHS regions	DHHS regions
Age classes			
Single years	x	x	x
60-64			
65+	x		x
65-74, 75-84, 85+	x	x	x
Other:			
Under 55, 55-64	x	x	x

SPONSOR: National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Framingham Study**

Project Director: Robert Garrison, Chief
Field Studies Branch
National Heart, Lung, and Blood Institute
Federal Building
7550 Wisconsin Avenue, NW
Washington, DC 20205

PURPOSE: Prospective epidemiologic study of cardiovascular disease.

DESIGN: Representative sample of adults living in Framingham, Massachusetts, ages 30 to 62 in 1950 (approximately). Longitudinal study of 5,209 men and women with biennial examinations that are still continuing.

CONTENT: Biological, physical, social, demographic characteristics of 5,209 men and women with measurement of subsequent disease. Characteristics measured every two years and continuing.

YEARS OF DATA COLLECTION: 1948 to present. Study expected to continue.

PUBLICATIONS: The Framingham Study. William B. Kannel, M.D., and Tavia Gordon, Editors. This monograph and a complete bibliography available from contact person.

AVAILABILITY OF UNPUBLISHED DATA: None.

CONTACT: Robert Garrison
(301) 496-5826

SPONSOR: National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Framingham Study**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
x		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
x		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
x		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
x		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Framingham Study**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	5,209	
Under 65	initially	
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Honolulu Heart Program**

Project Director:
Robert D. Abbott, Statistician
Statistical Resource Section
Field Studies Branch
Division of Epidemiological and Clinical Applications
National Heart, Lung, and Blood Institute
Federal Building
7550 Wisconsin Avenue, NW
Washington, DC 20205

PURPOSE: To continue ongoing epidemiology and pathology studies of a cohort of 8,006 men of Japanese ancestry living in Hawaii who were born between 1900 and 1919 and enrolled in the Honolulu Heart Program in 1965.

DESIGN: The data collected consists of following the surviving members of the original 8,006 randomly selected men from a target population of 14,000 subjects. Response rates are nearly 100%. There are no repeat examinations with data collected through hospital discharge surveillance, mortality records, death certificates, and obituary notices. Data not linked to other files or samples.

CONTENT: Surveillance data from hospital discharge, mortality records, death certificates, and obituary notices, which include new cases of coronary heart disease, stroke, other cardiovascular diseases, and total mortality.

YEARS OF DATA COLLECTION: The study began in 1965 with a cardiovascular examination given to each subject. Repeat examinations occurred throughout the study. Current funding is for surveillance of morbidity and mortality events and has been extended to 1990. Repeat examinations are not being given.

PUBLICATIONS:
Kagan et al. J Chron Dis 1974; 27:345-64.
Yano, Reed, McGee. Am J Epid 1984; 119:653-66.
McGee et al. Am J Epid 1984; 119:667-76.

AVAILABILITY OF UNPUBLISHED DATA: Data available through published manuscripts. There are no unpublished tabulations or public-use data tapes.

CONTACT:
Robert D. Abbott
(301) 496-5826

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SPONSOR: National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Honolulu Heart Program**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
x		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
x		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
x		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
x		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: National Heart, Lung, and Blood Institute (NHLBI), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Honolulu Heart Program**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	8,006	near zero
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years	x		x
60-64	x		x
65+	x		x
65-74, 75-84, 85+	x		x
Other			

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Baltimore Longitudinal Study of Aging (BLSA)**

Project Director:
Richard C. Greulich, Scientific Director
National Institute on Aging
Gerontology Research Center
Francis Scott Key Medical Center
Baltimore, MD 21224

PURPOSE: To trace the effect of aging in humans.

DESIGN: Longitudinal study of community-dwelling volunteers who return every two years for reevaluation and are enrolled for their lifetime. During the 2 1/2 day biennial visit, a battery of physiological and behavioral tests are administered.

Recruitment of the male cohort began in 1958, and new subjects continue to be introduced to maintain the population. Age at entry ranged from 17 to 96 years. As of June 1984, 1,195 men have been tested at least once on some of the variables; over half have been tested 6 times or more. Recruitment of women began in 1978 and continues. Many are wives or daughters of the male BLSA members. As of June 1984, 381 women have been tested at least once--151 of whom have been tested 3 times or more on some of the variables.

CONTENT: Intensive studies of physiological and behavioral changes occurring over the entire adult life-span. Observations include medical, genetic, biochemical, body composition, neuromuscular function and exercise, renal function, pulmonary function, cardiovascular function, carbohydrate metabolism, immune system, personality, and cognitive performance variables.

YEARS OF DATA COLLECTION:
Male Sample: initiated in 1958; new subjects added throughout study; biennial visits.
Female Sample: initiated in 1978; recruitment continues; biennial visits.

There are plans to increase the number of female participants in the study as resources permit.

PUBLICATIONS: Normal Human Aging: The Baltimore Longitudinal Study of Aging, NIH Publication No. 84-2450, November 1984.

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Baltimore Longitudinal Study of Aging (BLSA)**

AVAILABILITY OF UNPUBLISHED DATA: BLSA data are active working files collected and maintained by an ongoing research study rather than archival data bases made available by a service entity. Therefore, access to BLSA data is conditioned on establishment of a collaborative arrangement with an NIA intramural scientist and requires a concrete research proposal subject to BLSA review policies. Qualified researchers interested in a collaborative project should contact Richard Greulich.

CONTACT: Principal investigator

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Baltimore Longitudinal Study of Aging (BLSA)**

TYPES OF DATA COLLECTED

Data File Public-Use Tape

DEMOGRAPHIC DATA
Educational level
Race
Ethnicity
Sex
Marital status
Migration or mobility

VITAL STATISTICS
Natality
Mortality
Marriage
Divorce

HOUSING
Type of dwelling
No. of persons in household
Relationship of persons in household

INCOME AND WEALTH
Labor force participation
Total income
Sources of income
Net assets

SOCIAL SERVICES

HEALTH RESOURCES
General hospitals
Private psychiatric hospitals
Public mental health hospitals
Nursing homes
Other institutional resources
Community-based resources
Health professions
Other professional resources

HEALTH EXPENSES
Costs of care
Out-of-pocket costs
Medicare
Medicaid
State expenditures
Private insurance

Data File Public-Use Tape

NOT APPLICABLE

HEALTH
Acute and chronic conditions
Disability days
Chronic limitations:
  of activity
  of mobility
Impairments
Usual activity status

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
Cognitive impairment scale
Behavior problems
Depression
Alcohol use
Drug abuse

CHANGES IN HEALTH STATUS
Morbidity
Functional limitations
Self-perceived health

FUNCTIONAL LEVELS
Social interaction
Activities of daily living
Instrumental activities of daily living

HEALTH CARE UTILIZATION
General hospital services
Nursing home services
Home health care
Rehabilitation
Mental health hospitalization
Mental health outpatient services
Alcohol and drug abuse centers
Physician services/visits
Dental services/visits
Prescription drugs
Other

OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Baltimore Longitudinal Study of Aging (BLSA)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample*		Nonresponse Rate
	Male	Female	
Total	583	323	
65+	254	131	

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* Active subjects who have returned in last 3 years.

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Not applicable		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR:	National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
TITLE:	**East Boston Study on the Natural History of Senile Dementia**
	Project Director: Lon R. White, M.D. Chief, Epidemiology Office Epidemiology, Demography, and Biometry Program National Institute on Aging Federal Building, Room 612 7550 Wisconsin Avenue Bethesda, MD 20892
PURPOSE:	To conduct epidemiologic research on dementia in late life.
DESIGN:	The noninstitutionalized population of East Boston 65 years of age or older was stratified on the basis of performance on a dementia screening test. Approximately 500 persons were included in the survey with a 25% nonresponse rate. This is a longitudinal survey; data will be collected from 1984 to 1987. It is anticipated that there may be a 10-20% attrition rate per year. Data will be linked to the NIA/East Boston EPESE file (see p. 316).
CONTENT:	Neuropsychological test results; neurological examination results; interview with the subject and a significant other.
YEARS OF DATA COLLECTION:	Data collection began about January 1984 and will continue through about July 1987. Analysis expected through 1989. Release of data expected approximately 1990.
PUBLICATIONS:	Abstracts and verbal presentations only, to date.
AVAILABILITY OF UNPUBLISHED DATA:	None.
CONTACT:	Lon R. White, M.D. (301) 496-1178

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **East Boston Study on the Natural History of Senile Dementia**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
x		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
x		Marriage
		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
x		General hospitals
x		Private psychiatric hospitals
x		Public mental health hospitals
x		Nursing homes
x		Other institutional resources
x		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
x		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
x		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **East Boston Study on the Natural History of Senile Dementia**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	500	
Under 65		
65-74	100	
75-84	220	
85+	180	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x		
Geographic data			
Largest unit	E. Boston		
Smallest unit	Household		
Age classes			
Single years	x		
60-64			
65+	x		
65-74, 75-84, 85+	x		
Other			

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Established Populations for Epidemiologic Studies of the Elderly (EPESE)**

Project Director: Joan Cornoni-Huntley
Deputy Associate Director
Epidemiology, Demography, and Biometry Program
National Institute on Aging
Federal Building, Room 612
7550 Wisconsin Avenue
Bethesda, MD 20892

PURPOSE: Establish new knowledge about the aging process, particularly disease prevalence and disease incidence.

DESIGN: Sample universe of four communities: East Boston, Mass.; Iowa and Washington Counties, Iowa; New Haven, Conn.; Durham, N.C.

Sample eligibility: age 65 or older.

Longitudinal study design: 5 years surveillance through annual contacts.

Response rates-Average: 81% at baseline initial survey; over 95% participate annually.

CONTENT: Baseline data were collected regarding the personal health habits, chronic conditions, diseases, functional capacity, attitudes, social supports, household composition, and other related topics and areas of interest. Annual contacts will emphasize hospitalizations, new disabilities, nursing home stays, and mortality as end points.

YEARS OF DATA COLLECTION:

December 1982: Baseline survey completed; data to be published in 1985-86.
December 1983: First annual follow-up completed; data to be published beginning in 1986.
December 1984: Second annual follow-up completed; data to be published beginning in 1987.
December 1985: Third annual follow-up completed; data to be published in 1988.
December 1986: Fourth annual follow-up completed; data to be published in 1989.
December 1987: Fifth annual follow-up completed; data to be published in 1990.

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Established Populations for Epidemiologic Studies of the Elderly (EPESE)**

PUBLICATIONS: Cornoni-Huntley, J., Ostfeld, A.M., Taylor, J.O., Wallace, R.L., et al., Establishment of Populations for Epidemiologic Studies of the Elderly: Study Design and Methodology. Submitted for publication, 1985.

Cornoni-Huntley, J., Ostfeld, A.M., Taylor, J.O., Wallace, R.B., et al., Established Populations for Epidemiologic Studies of the Elderly: Resource and Prevalence Data from the Baseline Survey. Submitted for publication, 1985.

AVAILABILITY OF UNPUBLISHED DATA: Data will appear in major journals. Unpublished data are not available in tabular form for public use. Public-use data tapes will be available around 1990.

CONTACT: Joan Cornoni-Huntley
(301) 496-1178

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Established Populations for Epidemiologic Studies of the Elderly (EPESE)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
x		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
		Sources of income
		Net assets
x		**SOCIAL SERVICES**
		HEALTH RESOURCES
x		General hospitals
x		Private psychiatric hospitals
x		Public mental health hospitals
x		Nursing homes
x		Other institutional resources
x		Community-based resources
x		Health professions
x		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
x		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
x		Home health care
		Rehabilitation
x		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
x		Prescription drugs
x		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Established Populations for Epidemiologic Studies of the Elderly (EPESE)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	14,000	18%
Under 65	------	
65-74	8,000	
75-84	4,700	
85+	1,300	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status	x		
Geographic data			
Largest unit	Specified community		
Smallest unit	Household		
Age classes			
Single years	x		
60-64			
65+	x		
65-74, 75-84, 85+	x		
Other			

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SPONSOR:	National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
TITLE:	**Survey of the Last Days of Life**
	Project Director: Dwight Brock, Chief Biometry Office Epidemiology, Demography, and Biometry Program National Institute on Aging Federal Building, Room 612 7550 Wisconsin Avenue Bethesda, MD 20892
PURPOSE:	To provide new information on the circumstances surrounding death among the elderly.
DESIGN:	A probability sample of decedents whose death certificates have been filed in Health Service Area #1 between October 1984 and October 1985. Approximately 1,500 death certificates will be sampled.
CONTENT:	Personal or telephone interviews are conducted with a designated informant listed on the death certificate. Questions are asked about selected chronic conditions at the time of death, the use of medical services shortly before death, and the functional health status at one year, one month, and the day before death. Questions are also asked about the presence of family and friends and whether the death was sudden or lingering.
YEARS OF DATA COLLECTION:	Data are currently being collected, beginning in January 1985, and are expected to be completed by March 1986.
PUBLICATIONS:	No publications available to date.
AVAILABILITY OF UNPUBLISHED DATA:	No data are available to date.
CONTACT:	Dwight Brock (301) 496-9795

SPONSOR: National Institute on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: Survey of the Last Days of Life

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
		Total income
		Sources of income
		Net assets
x		SOCIAL SERVICES
		HEALTH RESOURCES
x		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
x		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
		Out-of-pocket costs
x		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
x		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
x		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
x		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institutes on Aging (NIA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: Survey of the Last Days of Life

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	1,500	15%
Under 65		
65-74	750	
75-84 85+	750	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

570

SPONSOR:	National Institute of Child Health and Human Development
CONTRACTOR:	Georgetown University
TITLE:	**Study of Low Fertility Cohorts in the United States** Project Director: Jeanne Clare Ridley Center for Population Research Georgetown University Washington, DC 20057
PURPOSE:	Study the determinants and consequences of the low fertility of the 1901-1910 birth cohorts.
DESIGN:	National multistage probability sample of white ever married women born July 1, 1900-June 30, 1910, born in United States or migrated to United States before age 30. Only the noninstitutionalized population was sampled. The sample size is 1,049 and the response rate 71.6%.
CONTENT:	Marital histories Pregnancy and live-birth histories Contraceptive use Fecundity Labor force participation Current health and functional status Socioeconomic data
YEARS OF DATA COLLECTION:	Interviews conducted in 1978; a follow-up of the original sample is planned for 1987. The planned follow-up will focus on the social supports of the women in the sample.
PUBLICATIONS:	Ridley, J.C., D.A. Dawson, and C.A. Bachrach. 1979. "The Extent of Sterility and Subfecundity Among the 1901-1910 Birth Cohorts." (abstract) Population Index. Bachrach, C.A., D.A. Dawson, and J.C. Ridley. 1979. "The Effects of the Depression on Fertility and Fertility Control: The Experience of the 1901-1910 Birth Cohorts." (abstract) Population Index. A complete list of publications can be obtained from Jeanne Claire Ridley.
AVAILABILITY OF UNPUBLISHED DATA:	Data from original interviews should be available on computer tape from National Technical Information Services, 5285 Port Royal Road, Springfield, VA 22161.
CONTACT:	Jeanne Clare Ridley (202) 625-3157

SPONSOR: National Institute of Child Health and Human Development

TITLE: **Study of Low Fertility Cohorts in the United States**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
		Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
x	x	Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
		Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute of Child Health and Human Development

TITLE: Study of Low Fertility Cohorts in the United States

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	1,049	28.4%
67-77	1,049	28.4%

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	X	X	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	Coterminous U.S.	Same	
Smallest unit	Town or open country	Same	
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other:			
By birth cohort, 1901-1910	X	X	X

SPONSOR: National Institute of Dental Research (NIDR), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Epidemiologic Survey of Oral Health in Adults, 1985**

Project Directors:
Ann Miller
Epidemiologist, Field Studies Section
Epi Branch, EODPP
National Institute of Dental Research
5333 Westbard Avenue
Bethesda, MD 20892

Janet Brunelle
Chief, Biometry Section
Epi Branch, EODPP
National Institute of Dental Research
5333 Westbard Avenue
Bethesda, MD 20892

PURPOSE: To establish prevalence of oral diseases in adult population of United States.

DESIGN: Sample of employed persons within continental United States ages 16-65 (approx. 14,000) and also a sample of mobile senior citizens who attend senior centers ages 65-75 and older (about 6,000). United States divided into 7 regions--select equal Ns from each region across all standard industrial codes (except agriculture). Cluster of employment places by county and senior centers within cluster.

CONTENT: Dental exams of tooth and root surfaces and supporting tissues to measure amount of dental caries on crowns and roots of teeth and measure gingivitis, calculus, and loss of attachment; enumeration of edentulous adults.

YEARS OF DATA COLLECTION: 1985: cross-sectional survey. Would like to repeat it every 5-7 years. Data collection now in progress.

PUBLICATIONS: None available yet.

AVAILABILITY OF UNPUBLISHED DATA: None available yet.

CONTACT:
Janet Brunelle
(301) 496-7716

SPONSOR: National Institute of Dental Research (NIDR), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Epidemiologic Survey of Oral Health in Adults, 1985**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
x		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
x		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

575

SPONSOR: National Institute of Dental Research (NIDR), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: Epidemiologic Survey of Oral Health in Adults, 1985

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	20,000	
Under 65	14,000	
65+	6,000	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	Continental U.S.		
Smallest unit	Region		
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			
65-69, 70-74, 75+	x		

SPONSOR: National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **National Alcoholism and Drug Abuse Program Inventory (NADAPI)**

Project Director:
George A. Kanuck, Program Analyst
Division of Epidemiology and Statistical Analysis
National Institute on Drug Abuse
Room 11 A 40, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

PURPOSE: To collect facility data in order to assess the extent of drug abuse and alcoholism treatment and prevention services available throughout the United States and its territories. The data, from publicly and privately funded units, will be used for production of a statistical summary and a national directory, in addition to its use as a universe for epidemiologic research.

DESIGN: All drug abuse and alcoholism treatment and prevention service providers are eligible for inclusion in the survey.

CONTENT: The 1984 inventory collected name and address information on alcoholism and drug abuse treatment and prevention units; physical location; specialized programs (including programs serving the elderly); types of services provided; ownership; and numbers of clients in treatment (inpatient, residential, and outpatient). In addition, in 1982, data were collected on capacity and utilization, sources of funding and unit staffing. Client and staffing data also included demographics (age, race, and sex).

YEARS OF DATA COLLECTION: Annually from 1974 to 1980 and biennially since then (1982 and 1984). Through 1982, the survey was known as the National Drug and Alcohol Treatment Utilization Survey (NDATUS). Data from the 1984 effort is currently under review.

PUBLICATIONS: 1982 data are available in the form of separate executive summaries from the two sponsoring institutes.

The 1984 National Directory is available from the sponsoring institutes. An alcohol and drug abuse executive summary is planned for late 1985.

AVAILABILITY OF UNPUBLISHED DATA: Data tapes from 1982 are available from each institute.

CONTACT: Diane Reznikov, NIDA or Patricia Reed, NIAAA

(301) 443-6637 (301) 443-3306

SPONSORS: National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **National Alcoholism and Drug Abuse Program Inventory (NADAPI)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
x		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSORS: National Institute on Drug Abuse (NIDA) and National Institute on Alcohol Abuse and Alcoholism (NIAAA), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: National Alcoholism and Drug Abuse Program Inventory (NADAPI)

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number of Programs*	Nonresponse Rate
Total		
Under 65		
65+	853	

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* 853 units identified themselves as providing alcohol and/or drug abuse treatment or prevention services to the "elderly."

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Not applicable		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR:	National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
TITLE:	**Annual Census of Patient Characteristics for State and County Mental Hospital Inpatient Services** Project Director: Michael J. Witkin Supervising Survey Statistician Survey and Reports Branch Division of Biometry and Epidemiology National Institute of Mental Health 5600 Fishers Lane Rockville, MD 20857
PURPOSE:	To develop aggregate data on patient characteristics for state and county mental hospital inpatient unit additions and resident patients.
DESIGN:	All state and county mental hospital inpatient additions and resident patients. Aggregate data by state.
CONTENT:	Aggregate counts by state for age, by sex, by diagnosis distributions.
YEARS OF DATA COLLECTION:	Annually, since 1949.
PUBLICATIONS:	Redick, R.W., Manderscheid, R.W., Witkin, M.J., and Rosenstein, M.J., *A History of the U.S. National Reporting Program for Mental Health Statistics 1840-1983*, DHHS Pub. No. ADM 83-1296, Washington, D.C., 1983.
AVAILABILITY OF UNPUBLISHED DATA:	By individual request.
CONTACT:	Michael J. Witkin (301) 443-3343

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Annual Census of Patient Characteristics for State and County Mental Hospital Inpatient Services**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
x		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
x		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Annual Census of Patient Characteristics for State and County Mental Hospital Inpatient Services**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Universe data collection by age category; 65+ is most refined.	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.		U.S.
Smallest unit	States		States
Age classes			
Single years			
60-64			
65+	x		x
65-74, 75-84, 85+			
Other			

SPONSOR: National Institute of Mental Health (NIMH), Department of Health and Human Services (DHHS)

TITLE: **Epidemiologic Catchment Area (ECA) Program Community Surveys**

Project Director: Ben Locke, Branch Chief
Jeff Boyd, Assistant Branch Chief,
Division of Biometry and Epidemiology
National Institute of Mental Health
5600 Fishers Lane
Rockville, MD 20857

PURPOSE: To assess the prevalence and incidence of mental illness and mental health services use in 5 different sites in the United States.

DESIGN: The sites were areas with a minimum population of 200,000: St. Louis, Mo. (Washington University); Baltimore, Md. (Johns Hopkins University); New Haven, Conn. (Yale University); Durham, N.C. (Duke University); Los Angeles, Calif. (UCLA).

1. Sample: complex, multistage, stratified household sample.
2. Response rate: 75-80% per site.
3. Sample includes both community (about 3,000 per site) and institutional population (about 500 per site). Institutions sampled include nursing homes, prisons, and mental hospitals.

CONTENT:

1. Data include frequencies of psychiatric disorders (DSM-3) using the NIMH Diagnostic Interview Schedule (DIS).
2. Core data collected at all 5 sites.
3. Each site collected additional data.
4. 4 sites with 2 waves of data.

YEARS OF DATA COLLECTION: Waves 1 and Waves 2 were collected between 1980 and 1985.

PUBLICATIONS: W.W. Eaton and L.G. Kessler (Eds.), Epidemiologic Field Methods in Psychiatry: *The NIMH ECA Program*, Academic Press, New York (in press).

Archives of General Psychiatry, October 1984. *The NIMH Epidemiologic Catchment Area Program*.

SPONSOR: National Institute of Mental Health (NIMH), Department of Health and Human Services (DHHS)

TITLE: **Epidemiologic Catchment Area (ECA) Program Community Surveys**

PUBLICATIONS: Archives of General Psychiatry, July 1985.
Blazer, D. et al: Psychiatric Disorders;
Helzer, J.E. et al: A Comparison of Clinical and Diagnostic Interview Schedule Diagnoses;
Anthony, J.C. et al: Comparison of the Lay Diagnostic Interview Schedule and a Standardized Psychiatric Diagnosis.

AVAILABILITY OF UNPUBLISHED DATA: At this time only through individual sponsors of research on the 5 sites. See contact below for more information. Public-use data may be available in 1987.

CONTACT: Ben Locke
(301) 443-3774

SPONSOR: National Institute of Mental Health (NIMH), Department of Health and Human Services (DHHS)

TITLE: **Epidemiologic Catchment Area (ECA) Program Community Surveys**

TYPES OF DATA COLLECTED

Data File Core	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x		Marriage
x		Divorce
		HOUSING
		Type of dwelling
x		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
		Net assets
x		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File Core	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
x		Mental health hospitalization
x		Mental health outpatient services
x		Alcohol and drug abuse centers
x		Physician services/visits
		Dental services/visits
		Prescription drugs
x		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

585

SPONSOR: National Institute of Mental Health (NIMH), Department of Health and Human Services (DHHS)

TITLE: **Epidemiologic Catchment Area (ECA) Program Community Surveys**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	About 18,000 (5 sites)	20-25%
Under 65		
65+	Oversamples of the elderly done at Duke, Hopkins, and Yale	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status	x		
Geographic data			
Largest unit	Catchment area		
Smallest unit	census tract		
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR:	National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
TITLE:	**Health Demographic Profile System's Inventory of Small Area Social Indicators** Project Director: David J. Jackson, Assistant Chief Demographic Research Section Division of Biometry and Epidemiology National Institute of Mental Health 5600 Fishers Lane Rockville, MD 20837
PURPOSE:	To use the U.S. decennial census to evaluate mental health needs assessment, program evaluation, and mental health or health epidemiology.
DESIGN:	The system consists of a set of small-area social indicators from the 1970 and 1980 U.S. censuses of population and housing that can be used to locate places with high risk of mental or physical disabilities or with special needs for mental or other health services; to estimate the needs of residential areas for services; to provide information on average background characteristics (social area analysis); and to provide estimates of the degree of homogeneity in a population or small residential area. All data are aggregated by geographic units.
CONTENT:	The file provides a general-purpose data base system containing census data for all tracts, minor civil divisions, counties, and states. The indicators include: socioeconomic status, occupational status, educational status, ethnic composition, household composition, area mobility, type and condition of housing, employment data, etc.
YEARS OF DATA COLLECTION:	1970 as the Mental Health Demographic Profile System. 1980 as the Health Demographic Profile System.
PUBLICATIONS:	National Institute of Mental Health, Series BN, No. 4. The Health Demographic Profile System's Inventory of Small Area Social Indicators. Goldsmith, H.F., Jackson, D.J., Doenhoefer, S., Johnson, W., Tweed, D.L., Stiles, D., Barbano, J.P., and Warheit, G.. DHHS Pub. No. ADM 84-1354. Washington, D.C., 1984.
AVAILABILITY OF UNPUBLISHED DATA:	Contact Marcus Sanchez, National Center for Health Statistics. Telephone: (301) 436-7137.
CONTACT:	David J. Jackson (301) 443-2908

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Health Demographic Profile System's Inventory of Small Area Social Indicators**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
	x	Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
	x	Marriage
	x	Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
	x	Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Health Demographic Profile System's Inventory of Small Area Social Indicators**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit		State	
Smallest unit		Census tracts	
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Inventory of General Hospital Psychiatric Services**

Project Director: Michael J. Witkin
Supervisory Statistician
Survey and Reports Branch
Division of Biometry and Epidemiology
National Institute of Mental Health
5600 Fishers Lane
Rockville, MD 20857

PURPOSE: To collect data on mental health resources in nonfederal general hospitals.

DESIGN: Universe of nonfederal general hospitals with separate psychiatric services.

CONTENT: Caseload, staffing, financial expenditures, services, and auspices of program.

YEARS OF DATA COLLECTION: Biennially, 1967 to present.

PUBLICATIONS: Redick, R.W., Manderscheid, R.W., Witkin, M.J., and Rosenstein, M.J., A History of the U.S. National Reporting Program for Mental Health Statistics 1840-1983. DHHS Pub. No. ADM 83-1296, Washington, D.C., 1983.

AVAILABILITY OF UNPUBLISHED DATA: By individual request.

CONTACT: Michael J. Witkin
(301) 443-3343

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Inventory of General Hospital Psychiatric Services**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
X		SOCIAL SERVICES
		HEALTH RESOURCES
X		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
X		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
X		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
X		Mental health hospitalization
X		Mental health outpatient services
X		Alcohol and drug abuse centers
X		Physician services/visits
X		Dental services/visits
X		Prescription drugs
X		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Inventory of General Hospital Psychiatric Services**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S.		U.S.
Smallest unit	Facility		Facility
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR:	National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
TITLE:	**Inventory of Mental Health Organizations**
	Project Director: Michael J. Witkin Supervisory Statistician Survey and Reports Branch Division of Biometry and Epidemiology National Institute of Mental Health 5600 Fishers Lane Rockville, MD 20857
PURPOSE:	To collect data on mental health resources in specialty mental health organizations.
DESIGN:	Universe of specialty mental health organizations.
CONTENT:	Caseload, staffing, financial revenues and expenditures, services, aggregate patient characteristics, and auspices of program.
YEARS OF DATA COLLECTION:	Biennially, 1967 to present.
PUBLICATIONS:	Redick, R.W., Manderscheid, R.W., Witkin, M.J., and Rosenstein, M.J., A History of the U.S. National Reporting Program for Mental Health Statistics 1840-1983. DHHS Pub. No. ADM 83-1296. Washington, D.C., 1983.
AVAILABILITY OF UNPUBLISHED DATA:	By individual request.
CONTACT:	Michael J. Witkin (301) 443-3343

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Inventory of Mental Health Organizations**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
x		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
x		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
x		Private psychiatric hospitals
x		Public mental health hospitals
		Nursing homes
x		Other institutional resources
x		Community-based resources
x		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
x		Out-of-pocket costs
x		Medicare
x		Medicaid
x		State expenditures
x		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
x		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
x		Mental health hospitalization
x		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Inventory of Mental Health Organizations**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not applicable	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth			
Social Security no.			
Veteran status			
Geographic data			
Largest unit	U.S		U.S.
Smallest unit	Facility		Facility
Age classes			
Single years			
60-64			
65+	x		x
65-74, 75-84, 85+			
Other			

595

SPONSOR:	National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)
TITLE:	**Patient Surveys of Inpatient Mental Health Settings**
	Project Director: Marilyn J. Rosenstein Supervisory Survey Statistician Survey and Reports Branch Division of Biometry and Epidemiology National Institute of Mental Health 5600 Fishers Lane Rockville, MD 20857
PURPOSE:	System was established to collect sample patient data on sociodemographic, clinical, and service characteristics of psychiatric inpatients.
DESIGN:	The universe is all inpatient admissions to specialty psychiatric inpatient services for given year. Sampling is done through a two-stage design with probability selection at each stage. The strata are ownership of hospital and bedsize. Sample sizes vary across facilities, depending on precision requirements.
CONTENT:	Sociodemographic, clinical, and service characteristics of psychiatric inpatient admissions.
YEARS OF DATA COLLECTION:	Approximately every five years, beginning in 1970.
PUBLICATIONS:	Redick, R.W., Manderscheid, R.W., Witkin, M.J., and Rosenstein, M.J., A History of the U.S. National Reporting Program for Mental Health Statistics 1840-1983, DHHS Pub. No. 83-1296, Washington, D.C., 1983.
AVAILABILITY OF UNPUBLISHED DATA:	By individual request.
CONTACT:	Marilyn J. Rosenstein (301) 443-3343

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Patient Surveys of Inpatient Mental Health Settings**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
x		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
x		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: National Institute of Mental Health (NIMH), National Institutes of Health (NIH), Department of Health and Human Services (DHHS)

TITLE: **Patient Surveys of Inpatient Mental Health Settings**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not available	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status	x		
Geographic data			
Largest unit	U.S.		U.S.
Smallest unit	U.S.		U.S.
Age classes			
Single years	x		x
60-64	x		x
65+	x		x
65-74, 75-84, 85+	x		x
Other			

SPONSOR: National Science Foundation (NSF)

TITLE: **General Social Surveys**

CONTRACTOR: National Opinion Research Center (NORC)

Project Directors:
James A. Davis, Principal Investigator
Tom W. Smith, Co-principal Investigator
National Opinion Research Center
University of Chicago
6030 South Ellis
Chicago, IL 60637

PURPOSE: The surveys are designed to measure trends (and constants) in social characteristics and opinions; and at the same time to make data available to social scientists who may not be affiliated with large research centers.

DESIGN: The sample is a national cross-section of adults, age 18 and older. The sample size for the studies is about 1,500 cases. For 1972 through 1974 the sampling plan is multistage probability down to the segment level with quotas applied at the final stage. The 1975-1976 sample design is experimental--half sampled as in previous years and half a strict multistage probability sample with predesignated respondents. From 1977 on, the surveys are full, multistage probability samples. A detailed description of the sampling plans appears in the codebooks that accompany the data or are available separately from Roper.

CONTENT: The 1972 questionnaire included approximately 100 items of interest to sociologists. Later questionnaires were expanded by about 50%. The schedule is divided into background characteristics and opinion items, for example, family and life-cycle; socioeconomic status; social psychology; satisfaction and happiness; crime, punishment, and violence; health; leisure; use of alcohol; etc.

YEARS OF DATA COLLECTION: Annually beginning in 1972, except for 1979 and 1981. The surveys are funded through 1987.

PUBLICATIONS: See Smith, Tom W., and Ward, Michelle, *Annotated Bibliography of Papers Using the General Social Surveys*. 5th Edition. 1984. Chicago: National Opinion Research Center.

AVAILABILITY OF UNPUBLISHED DATA: Distribution of data sets is handled by the Roper Center, University of Connecticut, Box U-1642, Storrs, CT 06268 or the Inter-university Consortium for Political and Social Research (ICPSR 8294), Box 1248, Ann Arbor, MI 48106. Data tapes are also in the collection of the Duke University Archive for Aging and Adult Development (DAAAD) Durham, N.C. 27710.

CONTACT: For technical questions, contact Tom W. Smith, NORC, (312) 962-1200.

SPONSOR: National Science Foundation (NSF)

TITLE: **General Social Surveys**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
	x	Migration or mobility
		VITAL STATISTICS
	x	Natality
	x	Mortality
	x	Marriage
	x	Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
	x	Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
	x	Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT
	x	Medicare/Medicaid: attitude on government medical care
	x	Psychological well-being
	x	Smoking

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SPONSOR: National Science Foundation (NSF)

TITLE: **General Social Surveys**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Numbers in Cumulated Samples	Nonresponse Rate
Total	18,000 (approx.)	
Under 65	13,850	
65-74	2,300	
75-84	1,400	
85+	450	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth		x	
Social Security no.			
Veteran status		x	
Geographic data			
Largest unit		9 census regions	
Smallest unit		3 size of place variables	
Age classes			
Single years		x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Public Health Service (PHS), Department of Health and Human Services (DHHS)

TITLE: **ASTHO Reporting System**

AGENCY: Public Health Foundation

Project Director:
Sue Madden, Program Director
ASTHO Reporting System
Public Health Foundation
1220 L Street, NW, Suite 350
Washington, DC 20005

PURPOSE: These data are collected in order to maintain a voluntary, uniform information data base on the public health programs and expenditures of the nation's state and territorial health agencies.

DESIGN: The universe consists of data collected annually from the 57 state and territorial health agencies. In 1983, 48 state health agencies (SHAs) reported.

CONTENT: The ASTHO Reporting System collects information on the public health programs and expenditures of the nation's state and territorial health agencies. Data are collected on personal health, environmental health, health resources, state laboratory, maternal and child health, handicapped children's services, tuberculosis control, and dental health. There have been some periodic revisions of the survey instruments from one year to the next.

YEARS OF DATA COLLECTION: Annually since 1970.

PUBLICATIONS: Public Health Agencies 1983 (a four volume set):

Vol. 1 Expenditures and Sources of Funds
Vol. 2 Services and Activities
Vol. 3 Services for Mothers and Children
Vol. 4 An Inventory of Programs and Block Grant Expenditures

(Also available for every year dating back to 1974.) A complete list of publications is available from Sue Madden.

AVAILABILITY OF UNPUBLISHED DATA: Data are available as unpublished tabulations from 1974 to 1983 and can be obtained by calling the Public Health Foundation.

CONTACT: Sue Madden
(202) 898-5600

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SPONSOR: Public Health Service (PHS), Department of Health and Human Services (DHHS)

TITLE: **ASTHO Reporting System**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
x		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
x		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
x		SOCIAL SERVICES
		HEALTH RESOURCES
x		General hospitals
		Private psychiatric hospitals
x		Public mental health hospitals
x		Nursing homes
x		Other institutional resources
x		Community-based resources
x		Health professions
x		Other professional resources
		HEALTH EXPENSES
x		Costs of care
x		Out-of-pocket costs
x		Medicare
x		Medicaid
x		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
x		Home health care
x		Rehabilitation
x		Mental health hospitalization
x		Mental health outpatient services
x		Alcohol and drug abuse centers
x		Physician services/visits
x		Dental services/visits
		Prescription drugs
x		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Public Health Service (PHS), Department of Health and Human Services (DHHS)

TITLE: **ARTHD Reporting System**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Reported by state	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	Reported by state		
Social Security no.			
Veteran status			
Geographic data			
Largest unit			
Smallest unit			
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Continuous Work History Sample (CWHS)**

Project Director: Creston M. Smith
Social Security Administration
2-B-2 Operations
6401 Security Boulevard
Baltimore, MD 21235

PURPOSE: The CWHS evolved at SSA as the best way of collecting demographic, earnings, employment, and benefit data for use in program research. The files are also used in actuarial activities, the Trustee's Report, and Trust Fund transfers.

DESIGN: The CWHS is a sample data set of administrative records, not a survey. The universe of the data set is all issued social security numbers (SSNs). The CWHS extracts data based on the serial digits of the SSN, usually at a 1% level. The CWHS currently consists of approximately 2.9 million SSNs. The data set is longitudinal in several of its data files. Annual earnings data are available starting in 1951.

CONTENT: The information collected is basically that which SSA needs to administer its retirement program. Data are collected from the:

SS-5	W-2 (W-3)	SS-4	1040 Schedule C
Year of birth	Wages	Coded Standard Industrial Class.	Self-employed (FICA only)
Race	Type of employment	State, county of employer	
Sex			
Place of birth			

The data are supplemented from various SSA claims forms. Earnings and claims data are collected annually.

YEARS OF DATA COLLECTION: Detailed annual earnings data are currently available for the period 1951-82. Some 1983 data should be available in late 1985. Files are updated annually with a 1- or 2-year lag for accounting and computer processes.

PUBLICATIONS: Some data are published annually in the Social Security Administration's Social Security Bulletin--Annual Statistical Supplement.

AVAILABILITY OF UNPUBLISHED DATA: Most data are produced ad hoc from the data files but some unpublished control counts and by-products of SSA activities exist. See contact person for release. There are severe restrictions on release of micro data collected from the W-2 form.

CONTACT: Creston M. Smith (301) 594-0361

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Continuous Work History Sample (CWHS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
	x	Race
		Ethnicity
	x	Sex
		Marital status
	x	Migration or mobility
		VITAL STATISTICS
		Natality
	x	Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Continuous Work History Sample (CWHS)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	2,889,000 (approx.)	
Under 65	2,101,000	
65-74	265,000	
75-84	214,000	
85+	291,000	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	USA		
Smallest unit	County		
Age classes			
Single years	x		
60-64	x		
65+	x		
65-74, 75-84, 85+	x		
Other			

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1978 Survey of Disability and Work**

Project Director: Mordechai Lando, Branch Chief
Office of Disability
Division of Disability Studies
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

PURPOSE: To measure the extent of disability in the United States and to determine the effects of disability on the economic, medical, and social welfare of disabled workers and their families.

DESIGN: The survey is based on a national sample of civilian noninstitutionalized adults ages 18-64. The sample was selected from two separate panels that totaled 11,739 persons. There were 9,859 completed interviews and 1,880 noninterviews. The data file is linked to selected items from the social security files, the Master Beneficiary Record (MBR), and the Summary Earnings Record (SER).

CONTENT: Household interviews were conducted by the Bureau of the Census from July through September 1978. The survey gathered economic, medical, and social data on a sample of the disabled and nondisabled working-age population.

See Bureau of the Census, Interviewer's Manual: 1978 Disability Survey.

YEARS OF DATA COLLECTION: July-September 1978.

PUBLICATIONS: Social Security Administration. Work Disability in the U.S.--A Chartbook. HEW Pub. No. 77-11978.

Data Book, Preliminary.

AVAILABILITY OF UNPUBLISHED DATA: Public-use data tape available. See Social Security Administration Users' Manual, 1978 Survey of Disability and Work, SSA Pub. No. 13-11732, 1981.
Special requests may be considered.

CONTACT: Mordechai Lando (301) 594-0300

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1978 Survey of Disability and Work**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
	x	Ethnicity
	x	Sex
	x	Marital status
	x	Migration or mobility
		VITAL STATISTICS
	x	Natality
	x	Mortality
	x	Marriage
	x	Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
	x	Sources of income
	x	Net assets
	x	SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
	x	Costs of care
	x	Out-of-pocket costs
	x	Medicare
	x	Medicaid
	x	State expenditures
	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
	x	Acute and chronic conditions
	x	Disability days
		Chronic limitations:
	x	of activity
	x	of mobility
	x	Impairments
	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
	x	Cognitive impairment scale
	x	Behavior problems
	x	Depression
	x	Alcohol use
	x	Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
	x	Social interaction
	x	Activities of daily living
	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
	x	General hospital services
	x	Nursing home services
	x	Home health care
	x	Rehabilitation
	x	Mental health hospitalization
	x	Mental health outpatient services
	x	Alcohol and drug abuse centers
	x	Physician services/visits
	x	Dental services/visits
	x	Prescription drugs
	x	Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1978 Survey of Disability and Work**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse
Total	11,739	1,880
Under 65	11,739	1,880
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth		x	
Social Security no.			
Veteran status		x	
Geographic data			
Largest unit		U.S.	
Smallest unit		Region	
Age classes			
Single years		x	
60-64		x	
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1982 New Beneficiary Survey**

Project Director:
Virginia P. Reno
Director, Program Analysis Staff
Office of Research, Statistics, and International Policy
Social Security Administration
Universal North Building, Room 1121
1875 Connecticut Avenue, NW
Washington, DC 20009

PURPOSE: The Social Security Administration has a congressional mandate to evaluate the programs it administers and report the economic status of beneficiaries.

DESIGN: The universe: noninstitutionalized program beneficiaries who entered payment status during a 12-month period from mid-1980 to mid-1981, and individuals ages 65-71 who were entitled to Medicare but had not received retired-worker benefits by July 1982.

The sample: 18,600 individuals in the following beneficiary categories: retired workers, disabled workers, spouses (wives, widows, divorced wives, divorced widows) and Medicare-only.

Nonresponse rate was less than 15%. Interview data are linked to data from administrative records--the Master Beneficiary Record and the Summary Earnings Record.

CONTENT: Information was collected on the following areas: household composition, employment history, pension coverage, health, income and assets, marital history, child care, program knowledge, and spouse characteristics.

YEARS OF DATA COLLECTION: Interviews were conducted from October through December 1982.

PUBLICATIONS: Introductory article and series of "First Findings" reports in the Social Security Bulletin in November 1983, January 1985, February 1985, and March 1985. Other articles to follow throughout 1985 and 1986.

AVAILABILITY OF UNPUBLISHED DATA: Public-use data tape is in preparation, with a projected release date of early 1986.

CONTACT:
Virginia P. Reno
673-5704

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1982 New Beneficiary Survey**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
x	x	Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x	x	Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1982 New Beneficiary Survey**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total (60-71)	18,599	Less than 15%
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.	x		
Veteran status	x	x	
Geographic data			
Largest unit	48 states and D.C.	48 states and D.C.	48 states and D.C.
Smallest unit	Region	Region	
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1986 Survey of Supplemental Security Income (SSI) Recipients and the General Aged Population**

Project Director:
Charles A. Lininger, Director
Supplemental Security Income
  Survey Staff
Social Security Administration
1875 Connecticut Avenue, NW
Washington, DC 20009

PURPOSE: The data system currently being established is designed to provide information for responding to policy and operations questions and regulatory and legislative proposal cost estimates. The data system is designed to replace the 1974 Survey of Low-Income Aged and Disabled.

DESIGN: The universe includes (1) the Supplemental Security Income (SSI) adult (18+) population in current payment status who are not in certified Medicaid facilities and (2) aged (65+) persons not receiving SSI benefits who are represented in the Health Insurance Master File. Two samples will include a total of 8,500 SSI recipients (which include about 4,500 persons ages 65+) and 2,700 aged persons in the population. The samples, designed to be nationally representative, will be augmented with individual case record data from the operating Social Security Record System.

CONTENT: Survey content will include the following topical areas: (1) household composition and living arrangement; (2) employment and earnings; (3) health and functional status, housing and expenditures; (4) income and assets; (5) program experiences; and (6) residence and personal background characteristics.

YEARS OF DATA COLLECTION: The design calls for a one-time survey (1986). Data collection will begin in June 1986. Expected release dates for data have not been finalized but are projected for the spring of 1988.

PUBLICATIONS: None.

AVAILABILITY OF UNPUBLISHED DATA: A public-use tape is planned for 1988.

CONTACT:
Charles Lininger
(202) 673-5644

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1986 Survey of Supplemental Security Income (SSI) Recipients and the General Aged Population**

TYPES OF DATA COLLECTED

Expected Data File	Public-Use Tape*	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
x		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
x		Total income
x		Sources of income
x		Net assets
x		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
x		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x		Costs of care
x		Out-of-pocket costs
x		Medicare
x		Medicaid
x		State expenditures
x		Private insurance

Expected Data File	Public-Use Tape*	
		HEALTH
		Acute and chronic conditions
x		Disability days
		Chronic limitations:
		of activity
		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x		Physician services/visits
x		Dental services/visits
x		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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* A public use tape is planned for 1988.

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **1986 Survey of Supplemental Security Income (SSI) Recipients and the General Aged Population**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	Not available	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x		
Geographic data			
Largest unit	State		
Smallest unit	County		
Age classes			
Single years	x		
60-64	x (SSI only)		
65+	x		
65-74, 75-84, 85+	x		
Other			

SPONSOR:	Social Security Administration (SSA), Department of Health and Human Services (DHHS)
TITLE:	**Retirement History Study**
	Project Director: Karen A. Schwab Division of Retirement and Survivors Studies Office of Retirement and Survivors Insurance Social Security Administration 1-B-10 Annex Baltimore, MD 21207
PURPOSE:	To provide data on the aspects of American retirement that affect and are affected by the provisions of the social security laws.
DESIGN:	The universe was men and nonmarried women ages 58-63 in 1969, previously interviewed by the Census Bureau in its Current Population Surveys. Of 12,549 persons eligible for interview in 1969, 11,153 were interviewed (11% noninterview rate). The study was longitudinal, with interviews conducted in 1969, 1971, 1973, 1975, 1977, and 1979: 75% of the sample originally interviewed in 1969 remained in the sample through the entire study. The data from the interviews were merged to two Social Security Administrative records--the earnings record and the beneficiary record.
CONTENT:	Information was gathered on work, health, health expenses, medical care, living arrangements, activity patterns (1975, 1977, 1979), and financial characteristics. There were some variations in questionnaire content from year to year.
YEARS OF DATA COLLECTION:	All data have been released for public use. Data collection years were 1969, 1971, 1973, 1975, 1977, 1979.
PUBLICATIONS:	Almost 65 (1976, HEW, Research Report No. 49). Articles since then have appeared in the Social Security Bulletin, and numerous economic and other social science journals. A collection of articles based on the 1971-1979 waves will be published by SSA late 1985 or early 1986.
AVAILABILITY OF UNPUBLISHED DATA:	All data are available on public-use data tapes. They can be purchased from the National Archives, Machine-Readable Records Administration, Washington, DC 20408.

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Retirement History Study**

Data tapes are in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, (ICPSR), Ann Arbor, MI 48106.
ICPSR 7739, 7683, 7684, 7685, 7859, 7931.

Data are also in the collection of the Duke University Archive for Aging and Adult Development (DAAAD), Durham, NC 27710.

CONTACT: Karen A. Schwab
(301) 597-6857

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Retirement History Study**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
		Ethnicity
x		Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
		Natality
x	x	Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
x	x	Costs of care
x	x	Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
x	x	State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x	x	Morbidity
x	x	Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
		Home health care
		Rehabilitation
x	x	Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
x	x	Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Retirement History Study**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total		
Under 65	11,153-1969	11%
65+	6,240-1979	25%

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	National		
Smallest unit	National		
Age classes			
Single years			
60-64	x	x	
65+	x	x	

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Supplemental Security Income Medicaid Institution Turnover (SSIMIT) Files**

Project Director:
Howard Oberheu, Research Analyst
Office of Supplemental Security Income
Social Security Administration
1875 Connecticut Avenue, NW
Washington, DC 20009

PURPOSE: To study Supplemental Security Income (SSI) beneficiaries that enter Medicaid institutions.

DESIGN: All SSI beneficiaries that entered Medicaid institutions between February 1982 and January 1983 are tracked for at least 24 months. Data are extracted from the supplemental security record, which is matched with Medicaid institution files for selected months.

CONTENT: Demographic and program characteristics of individuals entering Medicaid institutions and information about the institutions they enter.

YEARS OF DATA COLLECTION: February 1982 through January 1983 cohorts with follow-up for at least 24 months. Data base development is in process.

PUBLICATIONS: None.

AVAILABILITY OF UNPUBLISHED DATA: Data tapes may be available at completion of the study.

CONTACT:
Howard Oberheu
(202) 673-6305

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Supplemental Security Income Medicaid Institution Turnover (SSIMIT) Files**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
x		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Supplemental Security Income Medicaid Institution Turnover (SSIMIT) Files**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	106,095	
Under 65	26,000	
65+	80,095	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	U.S.		
Smallest unit	U.S.		
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Yearly Continuous Disability History Sample (CDHS)**

Project Director: Audrey Coe, Mathematical Statistician
Office of Disability
Division of Disability Studies
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235

PURPOSE: To furnish statistics on the operations of the social security disability program and the characteristics of the claimant population.

DESIGN: The CDHS is a yearly 20% simple random sample of initial disability claims processed by the Social Security Administration. The 1983 sample contained approximately 300,000 records. The sample is linked to the Master Beneficiary Record (MBR) and the Summary Earnings Record (SER).

CONTENT: The basic data set comprises: personal characteristics--sex, race, date of birth, occupation; agency decision--allowance/denial, legal basis, medical diagnosis, onset date; payment history--worker and family payments; annual earnings.

See Division of Disability Studies, Users' Manual for the 1976 Continuous Disability History Sample (CDHS) Restricted Use Data File.

YEARS OF DATA COLLECTION: Annually since 1975. The latest available file is for 1983.

PUBLICATIONS: Social Security Administration, *Disabled Applicant Statistics*.

AVAILABILITY OF UNPUBLISHED DATA: Special requests for tabulations may be considered, but data files are subject to restricted use.

CONTACT: Audrey Coe (301) 594-0721

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Yearly Continuous Disability History Sample (CDHS)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x		Educational level
x		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
x		Disability days
		Chronic limitations:
		of activity
x		of mobility
x		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Social Security Administration (SSA), Department of Health and Human Services (DHHS)

TITLE: **Yearly Continuous Disability History Sample (CDHS)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	300,000	
Under 65	300,000	
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	National		National
Smallest unit	State		State
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

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SPONSOR: Survey Research Center, University of Michigan

TITLE: **Survey of Consumer Finances (SCF)**

Project Director: Richard T. Curtin, Director
Surveys of Consumers
Survey Research Center
University of Michigan
Box 1248
Ann Arbor, MI 48106

PURPOSE: For analysis of household assets and debts.

DESIGN: National area probability sample.
Representative of all private U.S. households.
n = 4262. Response rate = 75%.

CONTENT: Dollar amounts on all assets and debts.

YEARS OF DATA COLLECTION: Various years 1946-83. A follow-up phone survey is planned for 1986.

PUBLICATIONS: Survey of Consumer Finances. Survey Research Center, University of Michigan. Various years.

AVAILABILITY OF UNPUBLISHED DATA: National Technical Information Service (PB85-217594)
5285 Port Royal Road
Springfield, VA 22161

Data tapes are also available from the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

CONTACT: Richard T. Curtin
(313) 763-5224

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SPONSOR: Survey Research Center, University of Michigan

TITLE: **Survey of Consumer Finances (SCF)**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
	x	Educational level
	x	Race
		Ethnicity
	x	Sex
	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
	x	Type of dwelling
	x	No. of persons in household
	x	Relationship of persons in household
		INCOME AND WEALTH
	x	Labor force participation
	x	Total income
	x	Sources of income
	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
		Behavior problems
		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Survey Research Center, University of Michigan

TITLE: **Survey of Consumer Finances (SCF)**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	4,262 households	25%
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth		x	
Social Security no.			
Veteran status		x	
Geographic data			
Largest unit	U.S.	U.S.	
Smallest unit			
Age classes			
Single years	x	x	
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: University of Kansas Long-Term Care Gerontology Center and Kansas Department of Social and Rehabilitative Services

TITLE: **Kansas Comprehensive Assessment**

Project Director:
Russell C. Mills, Director
University of Kansas Long Term Care
Gerontology Center
39th and Rainbow Boulevard
Kansas City, KS 66103

PURPOSE: Collect standardized data on all Kansas eligible applicants for Medicaid coverage of adult care home costs, for future policy and management analysis.

DESIGN: The state of Kansas began, about 3 years ago, a prenursing home admission assessment program, which is obligatory for Medicaid-eligible persons. Included in the assessment is a comprehensive multidisciplinary functional assessment, containing about 450 different data elements. The Long Term Care Gerontology Center has received (and is still receiving) all the assessments and computerized them (on a microcomputer system). At present over 8,000 persons are in the file, and 250-300 per month are being entered.

Every financially eligible applicant for Medicaid coverage of adult care home costs in Kansas is assessed by a team consisting of a case worker (social work) and a registered nurse (usually from county health department). Assessment is required whether applicant is for admission from home or for coverage after admission from hospital or when converting from private pay. Decision to provide Medicaid coverage requires positive recommendation by team, based on assessment results.

Later recommendations also include whether a person, if eligible for Medicaid coverage of adult care home costs, should be given the option of community-based services and case management (HCBS Title XIX Waiver). Follow-up and tracking of these HCBS-eligible clients is occurring. Data are computerized in linked files.

CONTENT: Demographic, living arrangements, health problems, number of medications, social support, mental and emotional status, functional and ADL status, living environment, use of community-based services, needs for assistance.

YEARS OF DATA COLLECTION: 1982 to date. Planned to continue.

SPONSOR:	University of Kansas Long-Term Care Gerontology Center and Kansas Department of Social and Rehabilitative Services
TITLE:	**Kansas Comprehensive Assessment**
PUBLICATIONS:	None yet.
AVAILABILITY OF UNPUBLISHED DATA:	Available by specific arrangements.
CONTACT:	Russell C. Mills (913) 588-1203

SPONSOR: University of Kansas Long-Term Care Gerontology Center and Kansas Department of Social and Rehabilitative Services

TITLE: **Kansas Comprehensive Assessment**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
x		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x		Marriage
x		Divorce
		HOUSING
x		Type of dwelling
x		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
x		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
x		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
x		Functional limitations
x		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
x		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: University of Kansas Long-Term Care Gerontology Center and
Kansas Department of Social and Rehabilitative Services

TITLE: **Kansas Comprehensive Assessment**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	8,000	
Under 65	500	
65+	7,500	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State (KS)		
Smallest unit	County		
Age classes			
Single years	x		
60-64			
65+			
65-74, 75-84, 85+			
Other			

SPONSOR: Urban Institute

TITLE: **Older Americans Resources and Services (OARS), Merged Data Set**

Project Director:
William Scanlon
Principal Research Associate
Health Policy Center
Urban Institute
2100 M Street, NW
Washington, DC 20037

PURPOSE: For the analysis of long-term care needs, resources, and service use among aged community residents.

DESIGN: The universe was the elderly population in four communities: Cleveland, Ohio; Eastern Kentucky; Lane County, Oregon; and the State of Virginia. Each sample was designed to be self-weighting. A description of the data years, sample size, and estimated universe is shown below.

Location	Organization Administering Survey	Date	Number of Respondents[a]	Estimated Universe[b]
Cleveland, Ohio	General Accounting Office	1976[c]	1,311	74,431
Eastern Kentucky	General Accounting Office	1977	156	7,324
Lane County, Oregon	General Accounting Office	1977	873	26,341
Virginia	Virginia Center on Aging	1979	1,530	505,304

(a) Excluding the Cleveland SSI sample and persons under 65.

(b) Number of persons 65 plus as reported in the 1980 Census of Population.

(c) The Cleveland data used are from a resurvey of persons interviewed first in 1975. A third survey was made in 1984. Follow-up of the original 1975 sample of 1,600 persons 65+ included 800 survivors 74+, 650 of whom were interviewed. The 1984 survey was conducted by Amasa B. Ford, Professor, Cleveland Study of the Elderly, Case Western Reserve University, Cleveland, Ohio 44106.

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SPONSOR: Urban Institute

TITLE: **Older Americans Resources and Services (OARS), Merged Data Set**

CONTENT: The OARS instrument involves two components--a functional assessment and a survey of service utilization. The functional assessment includes the domains of mental health, physical health, activities of daily living and instrumental activities of daily living, dependencies, social resources, and economic resources. The service utilization inventory covers 28 service types ranging from job placement assistance to personal care.

YEARS OF DATA COLLECTION: See Design.

PUBLICATIONS: Urban Institute Working Paper 1466-31; June 1983. Long-Term Care Needs, Resources and Service Use Among Aged Community Residents: Evidence from Four Local Surveys. William Scanlon and Carol Hamcke.

AVAILABILITY OF UNPUBLISHED DATA: Data from the OARS instruments available on public-use data tapes from the Urban Institute. A tape from the General Accounting Office's "Study of the Well-being of Older People in Cleveland, Ohio, 1975-1976" (ICPSR 7773) is in the collection of the National Archive of Computerized Data on Aging maintained by the Inter-university Consortium for Political and Social Research, P.O. Box 1248, Ann Arbor, MI 48106.

Data also used in the report prepared by the Urban Institute, "Project to Analyze Existing Long-Term Care Data."

The data collected in Cleveland in 1984 will be available in 1985. Unpublished papers may be obtained from Amasa B. Ford, as follows:

- "Social Support and Active Life Expectancy"
- "Symptoms, Medical Diagnosis, and Functional Assessment of Elderly in Community"
- "Changes in Health and Function Among Cleveland's Elderly: Preliminary Analysis of Follow-up to GAO Study"

CONTACT:
William J. Scanlon
Georgetown University Health Policy Center
(202) 625-2610

Margaret B. Sulvetta
The Urban Institute
(202) 857-8645

For 1984 Cleveland follow-up, contact:
Amasa B. Ford
Case Western Reserve University
(216) 368-3718

SPONSOR: Urban Institute

TITLE: **Older Americans Resources and Services (OARS), Merged Data Set**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
		No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
x	x	**SOCIAL SERVICES**
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
x	x	Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x	x	Cognitive impairment scale
		Behavior problems
x	x	Depression
x	x	Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
x	x	Morbidity
x	x	Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
x	x	Rehabilitation
x	x	Mental health hospitalization
x	x	Mental health outpatient services
		Alcohol and drug abuse centers
x	x	Physician services/visits
		Dental services/visits
x	x	Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Urban Institute

TITLE: **Older Americans Resources and Services (OARS), Merged Data Set**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE (See Design)

Age	Number in Sample	Nonresponse Rate
Total		
Under 65		
65-74	See DESIGN	
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status			
Geographic data			
Largest unit	State (VA)	State (VA)	
Smallest unit	City (Cleveland)	City (Cleveland)	
Age classes			
Single years	x	x	

SPONSOR:	Veterans Administration (VA)
TITLE:	**Annual Patient Census File**
	Project Director: Michael M. Lawson, Director Medical Administration Service Veterans Administration 810 Vermont Avenue, NW Washington, DC 20420
PURPOSE:	To collect data on veterans hospitalized in VA Medical Centers.
DESIGN:	The Annual Patient Census File is a by-product of the Patient Treatment File.
CONTENT:	Demographic, diagnostic, and surgical data on veterans hospitalized on a specific day during the year. Latest year available--1984.
YEARS OF DATA COLLECTION:	Annual.
PUBLICATIONS:	Selected reports for the Administrator's Annual Report to Congress.
AVAILABILITY OF UNPUBLISHED DATA:	Requests are considered. Call Information and Reports Management Service, (202) 389-2177.
CONTACT:	Michael M. Lawson (202) 389-2180

SPONSOR: Veterans Administration (VA)

TITLE: **Annual Patient Census File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tapo	
		DEMOGRAPHIC DATA
		Educational level
x		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
x		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

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SPONSOR: Veterans Administration (VA)

TITLE: **Annual Patient Census File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Universe	Nonresponse Rate
Total	75-80,000	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x		
Geographic data			
Largest unit	Nation		
Smallest unit	Zip code		
Age classes			
Single years	*		
60-64	*		
65+	*		
65-74, 75-84, 85+	*		
Other			

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* Data aggregated by using date of birth.

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SPONSOR: Veterans Administration (VA)

TITLE: **Hospital Based Home Care (HBHC) Information System**

Project Director:
Yasuko Shiraishi, Chief
Hospital Based Home Care Programs
Office of Geriatrics and
Extended Care
Veterans Administration
810 Vermont Ave., NW
Washington, DC 20420

PURPOSE: To enable field program managers to monitor patient care activities and program administration activities, both of which are then related to program costs. The clinical applications of the data include developing the patient treatment plan, 60-day progress review (required by the Joint Commission on Accreditation of Hospitals), HBHC discharge planning, and HBHC discharge. The data are also used for the required quality assurance studies. The administrative applications include the monitoring of the number of home visits by provider and provider discipline, length of stay, and turnover rate.

DESIGN: All 49 HBHC programs collect data on all program admissions, discharges, and visits by place of visit.

CONTENT: The information collected is the complete data items of the Long-Term Care Minimum Data Set of the National Center for Health Statistics, with the addition of VA specific data, i.e., period of military service.

YEARS OF DATA COLLECTION: Collected by fiscal year for clinical and administrative purposes only.

PUBLICATIONS: None.

AVAILABILITY OF UNPUBLISHED DATA: Data are available for 1983 and FY 1984, as unpublished tabulations. Can be obtained from project head.

CONTACT:
Yasuko Shiraishi
(202) 389-3692

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SPONSOR: Veterans Administration (VA)

TITLE: **Hospital Based Home Care (HBHC) Information System**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
x		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
x		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
		of activity
		of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
x		Behavior problems
x		Depression
		Alcohol use
		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
x		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
		Nursing home services
x		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Veterans Administration (VA)

TITLE: Hospital Based Home Care (HBHC) Information System

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Universe	Nonresponse Rate
Total	7,523	
Under 65	3,273	
65-74	1,956	
75-84	1,137	
85+	1,157	

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x		
Geographic data			
Largest unit	U.S.		
Smallest unit	Zip code		
Age classes			
Single years	x		
60-64	x		
65+	x		
65-74, 75-84, 85+	x		
Other			

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SPONSOR: Veterans Administration (VA)

TITLE: **1979 National Survey of Veterans**

CONTRACTOR: Louis Harris and Associates, Inc.

Project Director:
Richard Hammond
Statistician, Research Division
Veterans Administration
810 Vermont Avenue, NW
Washington, DC 20420

PURPOSE: Section 219 of Chapter 3 of Title 38 United States Code stated that the VA administrator ". . . shall measure and evaluate on a continuing basis the impact of all programs authorized under this title, in order to determine their effectiveness . . . ." In carrying out this section it gave authority to ". . . collect, collate, and analyze . . . data regarding participation . . . provision of services, categories of beneficiaries."

DESIGN: The selected sample for the survey consisted of 11,230 male veterans from the retiring Current Population Survey (CPS) rotation groups in the March through September 1978 "A" and "C" sample. Of these, 492 were later classified as nonveterans. There were 9,292 completed interviews, for a 93% response rate.

CONTENT: The survey covered basic demographic variables, data relevant to specific programs of the VA (medical, compensation and pension, insurance, education and training, home loans, burial benefits), and data specific to Vietnam era veterans related to combat experience and readjustment experiences.

YEARS OF DATA COLLECTION: 1979.

PUBLICATIONS:
1979 National Survey of Veterans, Veterans Administration, Office of the Controller, Research Monograph No. 14, December 1980.
Disabled Veterans and Their Usage of VA Programs, Veterans Administration, (SB-70-83-1), January 1983.
Usage of Multiple VA Programs, Veterans Administration, (SB70-83-5), August 1983.

AVAILABILITY OF UNPUBLISHED DATA: The responses to all questions on the survey are available on a public-use data tape. Contact project director.

CONTACT:
Robert H. Feitz
VA
(202) 389-3052

SPONSOR: Veterans Administration (VA)

TITLE: 1979 National Survey of Veterans

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations: of activity of mobility
		Impairments
		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
x	x	Behavior problems
x	x	Depression
x	x	Alcohol use
x	x	Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
x	x	Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Veterans Administration (VA)

TITLE: 1979 National Survey of Veterans

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	9,292 (out of 11,230 eligible, or 92% response rate)	
Under 65	8,428	
65-74	595	
75-84	269	
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	Region	Region	Region
Age classes			
Single years	x	x	x
60-64	x	x	x
65+	x	x	x
65-74, 75-84, 85+	x	x	x
Other			

SPONSOR:	Veterans Administration (VA)
TITLE:	**Patient Treatment File**
	Project Director: Michael M. Lawson Director, Medical Administration Service Veterans Administration 810 Vermont Avenue, NW Washington, DC 20420
PURPOSE:	The system collects and stores demographic, diagnostic, and surgical data on veterans treated and discharged from VA hospitals.
DESIGN:	The universe is all patients treated and discharged from VA hospitals.
CONTENT:	Demographic, diagnostic, and surgical information on patients discharged from VA hopsitals. Starting in FY 1984, a method of patient tracking during an episode of care was introduced.
YEARS OF DATA COLLECTION:	Continuously since 1969.
PUBLICATIONS:	Some statistical data for the Administrator's Annual Report to Congress are drawn from the Patient Treatment File.
AVAILABILITY OF UNPUBLISHED DATA:	Requests can be considered. Call Information and Reports Management Service, (202) 389-2177.
CONTACT:	Michael M. Lawson (202) 389-2180

SPONSOR: Veterans Administration (VA)

TITLE: **Patient Treatment File**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
x		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
x		Mortality
x		Marriage
x		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
x		Morbidity
x		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
		Social interaction
		Activities of daily living
		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Veterans Administration (VA)

TITLE: **Patient Treatment File**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	1 million/year	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status	x		
Geographic data			
Largest unit	Nation		
Smallest unit	Zip code		
Age classes			
Single years	*		
60-64	*		
65+	*		
65-74, 75-84, 85 +	*		
Other	*		

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* Data aggregated by using date of birth.

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SPONSOR: Veterans Administration (VA)

TITLE: **Survey of Aging Veterans, 1983**

Project Director: Robert H. Feitz
Statistician, Research Division
Veterans Administration
810 Vermont Avenue, NW
Washington, DC 20420

PURPOSE: To conduct a national survey of the needs, resources, and future expectations of veterans ages 55 and over. The data were to be used to project veterans' needs, in order to plan facilities and programs to meet these needs.

DESIGN: The survey was conducted among a nationally representative sample of veterans ages 55 and over using a national area probability sample of about 55,000 households. Interviewers screened 34,500 households to identify 3,886 eligible veterans. Of these, 3,013 (78%) interviews were actually completed.

CONTENT: The survey yields baseline data on the current social, economic, and health status of noninstitutionalized veterans ages 55 and older, as well as their pattern of utilization of VA facilities and benefits.

YEARS OF DATA COLLECTION: 1983.

PUBLICATIONS: Survey of Aging Veterans: A Study of the Means, Resources, and Future Expectations of Veterans Aged 55 and Over (RSM 70-84-3), Veterans Administration, March 1984.

The Aging Female Veteran (SAV 70-84-1), Veterans Administration, March 1984.

Health Insurance Coverage Among Veterans Aged 55 and Over (SAV) 70-85-1), January 1985.

National Cemetery and Headstone/Marker Programs (SAV 70-85-2), February 1985.

Current Health Status and the Future Demand for Health Care Programs and Social Support Services (SAV 70-85-3), Veterans Administration, March 1985.

AVAILABILITY OF UNPUBLISHED DATA: A public-use data tape containing the responses to all questions on the survey is available. Contact Richard Hammond (202) 389-2121.

CONTACT: Robert H. Feitz
(202) 389-3052

SPONSOR: Veterans Administration (VA)

TITLE: **Survey of Aging Veterans, 1983**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
x	x	Educational level
x	x	Race
x	x	Ethnicity
x	x	Sex
x	x	Marital status
x	x	Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
x	x	Marriage
x	x	Divorce
		HOUSING
x	x	Type of dwelling
x	x	No. of persons in household
x	x	Relationship of persons in household
		INCOME AND WEALTH
x	x	Labor force participation
x	x	Total income
x	x	Sources of income
x	x	Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
x	x	Medicare
x	x	Medicaid
		State expenditures
x	x	Private insurance

Data File	Public-Use Tape	
		HEALTH
x	x	Acute and chronic conditions
		Disability days
		Chronic limitations:
x	x	of activity
x	x	of mobility
x	x	Impairments
x	x	Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
		Cognitive impairment scale
x	x	Behavior problems
x	x	Depression
x	x	Alcohol use
x	x	Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
		Functional limitations
x	x	Self-perceived health
		FUNCTIONAL LEVELS
x	x	Social interaction
x	x	Activities of daily living
x	x	Instrumental activities of daily living
		HEALTH CARE UTILIZATION
x	x	General hospital services
x	x	Nursing home services
x	x	Home health care
x	x	Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
x	x	Alcohol and drug abuse centers
x	x	Physician services/visits
x	x	Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

SPONSOR: Veterans Administration (VA)

TITLE: **Survey of Aging Veterans, 1983**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Sample	Nonresponse Rate
Total	3,013 (out of 3,886 eligible, or 78% response rate)	
Under 65	1,977	
65-74	861	
75-84	175	
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x	x	
Social Security no.			
Veteran status	x	x	
Geographic data			
Largest unit	U.S.	U.S.	U.S.
Smallest unit	Region	Region	Region
Age classes			
Single years	x	x	x
60-64	x	x	x
65+	x	x	x
65-74, 75-84, 85+	x	x	x
Other			

SPONSOR: Veterans Administration (VA)

TITLE: **Survey of VA Long-Term Care Patients**

Project Director:
Philip E. Schaeffer
Project Coordinator
Allocation Development Service (134)
Veterans Administration
810 Vermont Avenue, NW
Washington, DC 20420

PURPOSE: Initially as a research base; subsequently to provide periodic workload data.

DESIGN: Initially 100% of VA nursing care patients and 20% of all other long term patients--subsequently 100% of VA nursing care patients and intermediate care patients.

CONTENT:

Initially
- Patient identification and demographic data
- Functional ability
- Diagnosis
- Nursing treatments and rehabilitation service

Subsequently
- Patient identification and demographic data
- Functional ability

YEARS OF DATA COLLECTION: To date: 9/83, 7/84, 9/84, 1/85, 4/85, 7/85, and 9/85. Plan to collect data on admission or transfer into units and semiannually.

PUBLICATIONS: None as yet.

AVAILABILITY OF UNPUBLISHED DATA: Address inquiries to project coordinator.

CONTACT:
(202) 389-3037
or
(202) 389-3640

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SPONSOR: Veterans Administration (VA)

TITLE: **Survey of VA Long-Term Care Patients**

TYPES OF DATA COLLECTED

Data File	Public-Use Tape	
		DEMOGRAPHIC DATA
		Educational level
		Race
		Ethnicity
x		Sex
		Marital status
		Migration or mobility
		VITAL STATISTICS
		Natality
		Mortality
		Marriage
		Divorce
		HOUSING
		Type of dwelling
		No. of persons in household
		Relationship of persons in household
		INCOME AND WEALTH
		Labor force participation
		Total income
		Sources of income
		Net assets
		SOCIAL SERVICES
		HEALTH RESOURCES
		General hospitals
		Private psychiatric hospitals
		Public mental health hospitals
x		Nursing homes
		Other institutional resources
		Community-based resources
		Health professions
		Other professional resources
		HEALTH EXPENSES
		Costs of care
		Out-of-pocket costs
		Medicare
		Medicaid
		State expenditures
		Private insurance

Data File	Public-Use Tape	
		HEALTH
x		Acute and chronic conditions
x		Disability days
		Chronic limitations:
x		of activity
x		of mobility
x		Impairments
x		Usual activity status
		ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH
x		Cognitive impairment scale
x		Behavior problems
x		Depression
x		Alcohol use
x		Drug abuse
		CHANGES IN HEALTH STATUS
		Morbidity
x		Functional limitations
		Self-perceived health
		FUNCTIONAL LEVELS
x		Social interaction
x		Activities of daily living
x		Instrumental activities of daily living
		HEALTH CARE UTILIZATION
		General hospital services
x		Nursing home services
		Home health care
		Rehabilitation
		Mental health hospitalization
		Mental health outpatient services
		Alcohol and drug abuse centers
		Physician services/visits
		Dental services/visits
		Prescription drugs
		Other
		OTHER BROAD CATEGORY FOR SAMPLING UNIT

654

SPONSOR: Veterans Administration (VA)

TITLE: **Survey of VA Long-Term Care Patients**

SELECTED ITEMS IN DATA SET

SIZE OF SAMPLE

Age	Number in Universe	Nonresponse Rate
Total	18,500	
Under 65		
65-74		
75-84		
85+		

AVAILABILITY AND LOCATION OF SPECIFIC DATA ITEMS

Item	Data File	Public-Use Tape	Published Tables
Date of birth	x		
Social Security no.	x		
Veteran status			
Geographic data			
Largest unit	Nation		
Smallest unit	VA hospital unit		
Age classes			
Single years			
60-64			
65+			
65-74, 75-84, 85+			
Other			

ACRONYMS

AARP	American Association of Retired Persons
ADL	Activities of daily living
AHA	American Hospital Association
AHS	American Housing Survey (HUD)
AoA	Administration on Aging (DHHS)
ASPE	Assistant Secretary for Planning and Evaluation (DHHS)
ASTHO	Association of State and Territorial Health Officers
BDMS	Bureau of Data Management and Strategy (HCFA)
BLS	Bureau of Labor Statistics
BLSA	Baltimore Longitudinal Study of Aging (NIA)
CCDB	County and City Data Book (Bureau of Census)
CDC	Centers for Disease Control
CDHS	Continuous Disability History Sample (SSA)
CO-STAT	County Statistics (Bureau of Census)
CPHA	Commission on Professional and Hospital Activities
CPI	Consumer Price Index (BLS)
CPS	Current Population Survey (Bureau of Census)
CWHS	Continuous Work History Sample (SSA)
DAAAD	Data Archive for Aging and Adult Development (Duke University)
DHEW	Department of Health, Education, and Welfare
DHHS	Department of Health and Human Services
DRA	Divorce-registration area
DRG	Diagnosis related groups
ECA	Epidemiologic Catchment Area (NIMH)
EPESE	Established Populations for Epidemiologic Studies of the Elderly (NIA)
FDA	Food and Drug Administration
FICA	Federal Insurance Contribution Act
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHANES	Hispanic Health and Nutrition Examination Survey (NCHS)
HI	Hospital Insurance Program (Medicare: HCFA)
HINDEX	Index to data collected in the HANES surveys (NCHS)
HUD	Housing and Urban Development (Department of)
IADL	Instrumental activities of daily living
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICPSR	Inter-university Consortium for Political and Social Research (University of Michigan)
IRS	Internal Revenue Service
LSOA	Longitudinal Study of Aging (NCHS)
MBR	Master Beneficiary Record (SSA)
MEDPAR	Medicare Provider Analysis and Review (HCFA)

MMACS	Medicare/Medicaid Automated Certification System (HCFA)
MRA	Marriage-registration area (NCHS)
MSA	Metropolitan Statistical Area
NAAAA	National Association of Area Agencies on Aging
NACDA	National Archive of Computerized Data on Aging (University of Michigan)
NADAPI	National Alcoholism and Drug Abuse Program Inventory
NAMCS	National Ambulatory Medical Care Survey (NCHS)
NASUA	National Association of State Units on Aging
NCHS	National Center for Health Statistics
NCHSR	National Center for Health Services Research and Health Care Technology Assessment
NCI	National Cancer Institute
NDATUS	National Drug and Alcohol Treatment Utilization Survey
NDI	National Death Index (NCHS)
NEISS	National Electronic Injury Surveillance System (Consumer Product Safety Commission)
NHANES	National Health and Nutrition Examination Survey (NCHS)
NHDS	National Hospital Discharge Survey (NCHS)
NHIS	National Health Interview Survey (NCHS)
NHLBI	National Heart, Lung, and Blood Institute
NIA	National Institute on Aging (NIH)
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIDR	National Institute of Dental Research
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NLTCDP	National Long-Term Care Channeling Demonstration Program (ASPE)
NMCES	National Medical Care Expenditures Survey (NCHSR with NCHS)
NMCUES	National Medical Care Utilization and Expenditure Survey (NCHS with HCFA)
NMES	National Medical Expenditure Survey (NCHSR)
NMFI	National Master Facility Inventory (NCHS)
NNHS	National Nursing Home Survey (NCHS)
NORC	National Opinion Research Center
NSF	National Science Foundation
NTIS	National Technical Information Service (Department of Commerce)
OARS	Older American Resources and Services (Duke University)
ORD	Office of Research and Demonstrations (HCFA)
ORSIP	Office of Research, Statistics, and International Policy (SSA)
PHS	Public Health Service
PSID	Panel Study of Income Dynamics (University of Michigan)
PSU	Primary sampling unit
SCF	Survey of Consumer Finances (University of Michigan)
SEER	Surveillance, Epidemiology, and End Results Program (NCI)
SER	Summary Earnings Record (SSA)
SHA	State health agency
SIPP	Survey of Income and Program Participation (Bureau of Census)
SMI	Supplementary Medical Insurance (Medicare: HCFA)

SMSA	Standard Metropolitan Statistical Area
SOA	Supplement on Aging (NHIS, NCHS)
SRC	Survey Research Center (University of Michigan)
SSA	Social Security Administration
SSI	Supplemental Security Income (SSA)
SSN	Social Security Number
USDA	United States Department of Agriculture
VA	Veterans Administration

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